

# Barriers and facilitators to accessing effective clinical supervision and the implementation of a clinical supervision exchange model in the Australian alcohol and other drugs sector

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## Abstract

**Introduction.** Internationally, clinical/practice supervision is considered essential in the development and maintenance of professional proficiency across health disciplines. Among alcohol and other drug (AOD) workers, however, access to effective clinical supervision is limited. This study examined perceived barriers and facilitators to: (i) AOD workers accessing effective clinical supervision; and (ii) effective implementation of a clinical supervision exchange model in the AOD sector. **Methods.** Qualitative interviews with frontline workers (n = 10) and managers (n = 11) employed by eight government and non-government AOD treatment services in Brisbane, Australia were undertaken. Interviews were audio recorded, transcribed and data were thematically analysed. **Results.** Frontline workers and managers shared similar views. Reported barriers and facilitators to accessing effective clinical supervision included limited time, the high cost of providers, availability of skilled clinical supervisors, supervisor–supervisee matching and supervision modality. Participants considered the implementation of a clinical supervision exchange model to be a resource-effective strategy to increase access to external, individual clinical supervision while also exposing workers to a greater diversity of perspectives, increasing sector collaboration and improving the perceived value of clinical supervision among the workforce. **Discussion and Conclusions.** The findings of this study suggest that limited time, cost and availability of skilled supervisors are primary barriers to AOD workers accessing high-quality clinical supervision. Implementation of a clinical supervision exchange model is perceived by frontline workers and service delivery managers to be a resource-effective strategy for increasing access to high-quality clinical supervision among workers. [O'Donnell C, Popovich S, Lee N, Hides L. Barriers and facilitators to accessing effective clinical supervision and the implementation of a clinical supervision exchange model in the Australian alcohol and other drugs sector. *Drug Alcohol Rev* 2022;41:988–1002]

**Key words:** clinical supervision, professional supervision, workforce development, alcohol and other drugs, treatment services.

## Introduction

Clinical supervision is the formal provision, by senior or qualified health practitioners, of intensive education and training that supports, directs and guides the clinical casework of supervisees [1]. It has long been considered as an important component in the development and maintenance of professional proficiency across health disciplines [2]. Today, in the fields of psychology and social work, practitioners require ongoing clinical supervision to retain registration or professional society membership

[3,4]. Among alcohol and other drug (AOD) workers, evidence suggests that clinical supervision reduces emotional exhaustion, increases organisational and occupational commitment [5], and is protective against workforce turnover [6]. While research examining the impact of clinical supervision among AOD workers is limited, studies have also found clinical supervision to have a range of benefits in other contexts. For example, findings suggest it increases self-efficacy, self-awareness and skill development among counsellors and therapists across disciplines [7]; reduces worker burnout [8,9] and

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improves client treatment outcomes in mental health settings [10,11]; and improves quality of care delivery among nurses [12,13].

In the AOD sector, clinical supervision has been identified as an essential workforce development strategy [2,14]. It is also commonly referred to as practice or professional supervision, particularly in community-based treatment settings [15]. The AOD sector is characterised by several distinct but related challenges, including: the varied mix of skills, experience, qualifications and knowledge of the workforce [16]; diverse and complex client cases [17,18]; difficulties recruiting and retaining workers [19]; limited professional development opportunities [20]; and high rates of stress and burnout among workers [16]. Together, these factors underpin the need for AOD workers to receive effective clinical supervision.

A recent Australian AOD workforce survey found that 87% of workers have access to some type of clinical supervision [16]. However, access to high-quality clinical supervision among AOD workers remains limited, as only 24% of AOD workers report having access to individual external clinical supervision, which is considered best practice within the sector [15,16,21,22]. Instead, line managers often act as clinical supervisors, which is problematic as it can result in role confusion, role ambiguity and could be perceived as a conflict of interest [2]. This is consistent with findings that, when delivered by a workers' direct line manager, the effectiveness of clinical supervision in health-care settings is diminished [23]. While research on barriers and facilitators to accessing high-quality clinical supervision among AOD workers is scarce, evidence from other health-related fields such as occupational therapy and physiotherapy suggests barriers to access include: lack of time; unavailability of skilled supervisors; and variable understanding of clinical supervision [24,25].

A clinical supervision exchange partnership between AOD treatment services has been suggested as a potentially effective strategy to increase access to external clinical supervision among AOD workers [26]. Recently, the Queensland Network of Alcohol and Other Drug Agencies (QNADA), the state-based peak body representing non-government AOD treatment services, worked in consultation with AOD treatment services to develop a clinical supervision exchange model intended to increase access to external clinical supervision among the workforce. The key feature of this model is that it operates on an exchange basis, whereby a worker from one organisation provides clinical supervision to staff of another organisation, and vice versa. A future pilot study will determine the feasibility of implementing a supervision exchange model and evaluate supervisor and supervisee outcomes.

The objectives of this study were to identify perceived barriers and facilitators, among frontline staff and managers from AOD treatment services, to:

1. receiving and providing high-quality clinical supervision in the AOD sector;
2. effective implementation of a clinical supervision exchange model in the AOD sector.

The findings of this study will inform how to best implement supervision in the AOD sector, including the design of a supervision exchange model.

## Methods

### Setting

Participants in the study were staff employed by one government and seven non-government AOD treatment organisations in Brisbane, Australia. Participating organisations ranged in size, from a single service to up to 10 services (i.e. 10 locations) in Brisbane. There are 75 publicly-funded AOD treatment services located within Brisbane [27] which has a population of approximately 2.08 million [28]. Services offered a variety of treatment types including residential rehabilitation, case management, counselling support and provision of pharmacotherapy to people experiencing problems with AOD use.

### Participants

Only staff aged over 18 were eligible to participate. Twenty-one participants (frontline workers:  $n = 10$ ; managers:  $n = 11$ ) were recruited. Participants comprised of frontline workers (nine female, one male) and managers (five female, six male) with professional backgrounds in counselling ( $n = 15$ ), social work ( $n = 4$ ) and psychology ( $n = 2$ ). Participants had a median of 11 years' experience (ranging from 3 months to 30 years;  $m = 12.4$ ) working in the AOD sector (frontline workers  $Mdn = 5.5$  years,  $m = 8.8$  years; managers  $Mdn = 17$  years,  $m = 15.4$  years). Among frontline workers, nine had experience receiving clinical supervision, four had experience both receiving and providing clinical supervision (including peer supervision) and one had no experience in either providing or receiving clinical supervision. Among managers, 10 had experience both receiving and providing clinical supervision while one manager had no experience in either.

### Procedure

Ethical clearance to conduct this study was obtained from the University of Queensland Human Research Ethics Committee on 12 November 2019 (approval number: 2019002606). To recruit participants, QNADA invited senior management from approximately one government and nine non-government AOD treatment organisations in Brisbane to participate in the study via email. Senior management was asked to forward the study information to frontline staff within their organisations via email and provide staff with the opportunity to voluntarily participate in the study during paid work hours. Interested staff contacted a research team member who obtained and recorded informed consent over the phone.

Interviews were directed by a semi-structured interview schedule developed by the research team (provided in Appendix S1, Supporting Information). Part one of the interview asked participants open questions about their: (i) experience of clinical supervision; and (ii) perceptions of barriers and facilitators to receiving and providing high-quality clinical supervision in the AOD sector. Part two explored participants' views about the implementation of a clinical supervision exchange model for AOD workers. Interviews took place from November 2019 to January 2020 and were conducted by the first author (CO). Interviews ranged from 22 to 61 min duration ( $M = 33.1$ ;  $SD = 10.4$ ). Eleven interviews were conducted in person and 10 were conducted online or over the phone. Interviews were audio recorded and professionally transcribed using a confidential transcription service.

### Data analysis

Data were thematically analysed using Braun and Clarke's six-step procedure [29]. Taking an inductive approach, data were coded using qualitative data analysis software, NVivo 12 [30]. CO read the transcripts several times to establish familiarity with the data and identify initial codes. Codes were refined over multiple readings before being grouped into themes and sub-themes. Themes were then discussed among CO and an independent coder who read all of the transcripts, generated codes and identified themes. Any discrepancies in the themes and sub-themes identified were discussed until consensus was reached. Separate thematic analyses were conducted for frontline workers' and managers' interview data. Identified themes and sub-themes were found to be consistent across datasets, and so the decision was made to present the findings together.

### Results

#### *Part one: Perceived barriers and facilitators to clinical supervision in the AOD sector*

Part one of the interview asked frontline workers and managers about their experiences of, and barriers and facilitators to, the provision of clinical supervision in the AOD sector. Four consistent themes emerged: (i) the need for AOD-specific clinical supervision; (ii) preferences for the delivery of clinical supervision; (iii) benefits of clinical supervision among; and (iv) barriers and facilitators to AOD workers accessing high-quality clinical supervision. Relevant quotes for each theme and sub-theme appear in Tables 1–4.

*Theme one: A need for AOD-specific clinical supervision.* Among participants, there was a perceived need for AOD workers to receive clinical supervision from someone who specialises in AOD treatment provision. Two sub-themes were identified: AOD workers experience high rates of burnout; and AOD treatment is a specialist field.

*Worker burnout:* A large majority of participants reported that the high rate of stress experienced by AOD workers necessitates the provision of clinical supervision, and attributed worker burnout to several factors. The first, but not necessarily most important, was the risk of vicarious trauma among workers ( $n = 9$ ), due to the high incidence of trauma exposure among AOD clients (see Table 1, Section A). Participants ( $n = 4$ ) also spoke about having limited time to reflect on their practice due to heavy workloads (see Table 1, Section B). They felt the workforce was at increased risk of stress due to the high proportion of AOD workers with a lived experience of AOD dependence ( $n = 4$ ; see Table 1, Section C), and some participants ( $n = 2$ ) spoke about feeling isolated when working remotely or doing outreach work (see Table 1, Section D).

*Alcohol and other drug treatment is a specialist field:* Participants described four factors that make AOD treatment a specialist field and necessitated the provision of clinical supervision by an AOD specialist. First, workers felt that people who access AOD treatment services have unique and varied treatment needs that require specialist knowledge to respond to effectively (see Table 1, Section E). Participants spoke about the specialist knowledge required to: support workers in navigating unrealistic expectations towards client treatment outcomes that can sometimes be held by clients, families, communities and other sectors; understand the nuances of AOD treatment and develop strategies to support clients experiencing problems with their AOD use; and validate AOD work as a profession (see Table 1, Section F). Participants ( $n = 4$ ) described the challenges

they face supporting clients with the high rates of stigma and discrimination they experience in the community (see Table 1, Section G). Stigma and discrimination were identified as significant barriers to people who use AOD accessing health services and workers making effective referrals to other services for their clients. Participants also described the emotional toll of advocating for clients and challenging stigma. Finally, participants ( $n = 14$ ) also spoke about the multiple and complex issues clients present with, and the need for specialist skills and knowledge to appropriately support them (see Table 1, Section H).

*Theme two: Preferences for the delivery of clinical supervision.* Participants described their preferences

for the delivery of clinical supervision among the AOD workforce. Interview data were categorised into two sub-themes: conceptual factors and operational factors.

**Conceptual factors:** Participants identified two main conceptual factors when discussing their preferences for clinical supervision delivery. Overwhelmingly, the most important element of clinical supervision among participants was that it provided a safe, honest, open space for them to discuss their work without fear of judgment ( $n = 14$ ; see Table 2, Section A). Participants ( $n = 19$ ) also felt that clinical supervision should support skill development and worker well-being (see Table 1, Section B).

**Operational factors:** When discussing their preferences for clinical supervision, participants identified

**Table 1.** Part one, theme one: A need for AOD-specific clinical supervision

Worker burnout	
A. Trauma exposure	'It is a tough industry. I mean we often can experience vicarious trauma through some of the stories that we hear from the clients that we work with... I think that's something we do need to pay some attention to—is that we do spend a lot of time hearing some not-so-good stuff and how do we unpack that?'—Manager
B. Heavy workloads	'It's very, very like, busy. I will come in and have a day planned out and the... things come up, young people can present in crisis, plans change all the time. It can be quite hectic. I definitely think that it would be beneficial to the AOD sector just to be able to have that opportunity to reflect, but to also just kind of stop for a minute to have that amount of time again'.—Frontline worker
C. Lived experience	'Usually we come into this profession because we have some lived experience, some history around that, whether it's a family member or a friend or our own stuff or our children. There's huge opportunities for being triggered... There's a real melting pot of stuff going on there. If they don't have someone to work with them on that, then you've got a pretty scary situation—scarier than our clients.'—Frontline worker
D. Isolation	'You know you kind of feel alone sometimes. Sometimes you're kind of working, especially if you're working remotely or outreach, you're kind of on your own amongst other non AOD workers.'—Frontline worker
AOD treatment is a specialist field	
E. Unique and varied needs and treatment objectives	'I suppose what I've found best is with somebody who knows alcohol and other drug treatment. I've had supervisors that are very experienced and very qualified in other areas, but not necessarily in drug and alcohol treatment and don't really understand the nuances of harm reduction and are recovery-focused.'—Manager
F. Societal expectations	'There needs to be recognition that really, in terms of outcomes and stuff like that, I think in a drug and alcohol setting there's a high expectation that we're going to cure people or whatever and I think that needs to be addressed in supervision... you know, you can't save everyone. And you can't, you've got to be aware that there's so much expectation around potential outcomes, from society and family members and all of that, but it's not all up to you as a worker, or even as a sector.'—Manager
G. Stigma and discrimination	'They'll try to go to other services and because they have problematic substance use on board, services don't want to have anything to do with them. They get kicked out of places, banned from places, lose their housing, lose their children. There's a lot of stigma and discrimination'—Frontline worker
H. Multiple and complex needs	'I think that it's sort of like the pointy end—well, it's not sort of like the pointy end—it is the pointy end. When someone comes in with problematic substance use on board, there is so much more attached to it. You know, whether it's gambling, homelessness and all of the stuff that comes with complex presentation, they're usually the people that no one else will see.'—Frontline worker

several important operational factors. The majority of participants ( $n = 14$ ) felt clinical supervision should be delivered on a regular basis to anyone who works directly with clients (see Table 2, Section C), and that the frequency should depend, to a degree, on the individual needs of supervisees ( $n = 15$ ; see Table 2, Section D). However, the majority of participants said that on average, workers should receive at least 1 hour of clinical supervision per month. Several participants felt it should be more frequent than once monthly, particularly for less experienced workers, while a few participants felt that it could be less frequent than monthly, particularly if there were other supports in place or the supervisees' work was less intensive. Participants ( $n = 8$ ) felt that

supervisors need to be trained in providing clinical supervision (see Table 2, Section E). Some participants, mostly managers, also felt that supervisees could benefit from clinical supervision training around how to prepare for clinical supervision and the responsibilities of supervisees. Several participants ( $n = 5$ ) preferred clinical supervision sessions to be structured (see Table 2, Section F), and several participants felt that clinical supervision training and delivery should be consistent across the sector (see Table 2, Section G).

*Theme three: Benefits of clinical supervision among AOD workers.* Participants spoke about benefits of clinical

**Table 2.** Part one, theme two: Preferences for the delivery of clinical supervision

Conceptual factors	
A. Safe space	'I feel trusted. I feel respected, I feel valued. It's consistent in that the person is reliable, nonjudgmental, and that's consistent throughout all the sessions. I feel respected. In a way it feels safe because it's almost predictable... It's a safe space where it's not chaotic, which work we do can be very chaotic and supervision is the opposite of that. It feels like a safe space, non-judgmental.'—Frontline worker
B. Educative and supportive	'It's about, it's certainly about professional development of the individual so, to me, the supervisor should be identifying gaps in learning and gaps in the skill, and seek to form a bit of a professional development plan. I think also it's looking at the relationship between the client and the worker, the clinician, and again, ensuring some of those nuances like transference and parallel process, some of those things are not occurring. It's that mirror so that in a way a worker can reflect on their practice through the eyes of their clinical supervisor.'—Manager
Operational factors	
C. All AOD workers receive it	'I suppose there are lots of different kinds of AOD workers. There are support workers, there are NSP workers and there are therapists -which is the category I belong to, the social workers. There are harm reduction workers. Even the receptionists here are front line workers, they are the first port of call. I think everybody should get supervision, but it looks different for different people.'—Manager
D. Regular and frequent	'I think for more experienced clinicians, monthly is a good time frame. I think for new grads or people that are new to the sector I really think it should start at fortnightly until there is a decision that they are feeling confident enough or competent enough to be stretching it out to the monthly.'—Manager
E. Supervisors and supervisees are trained	'I do think that you do need some training in being a supervisor, I don't think it's something that you can just, okay, I've been practicing for five years now, I'm ready to take people on.'—Manager 'I think that supervision should be purposeful and it's not up to just the supervisor to make it purposeful. It's really up to the supervisee to be prepared. I think that some training for the supervisee and preparing for supervision would probably be really useful. I think that's something that doesn't get covered a lot in supervision training—it has to be a good supervisee'.—Manager
F. Structured sessions	'You have your format and you stick to it, so you know what you're going to talk about and I like that. I like that structure. The structure for me is ... it is really important. It's something I can rely on. It's a safe space where it's not chaotic,—which, the work we do can be very chaotic—and supervision is the opposite of that.'—Frontline worker 'I've had supervision that I've had a number of supervisors who have assumed that I'm doing just fine and then people quite openly told me that I don't need supervision and let's just go for a coffee or something and then I will feel really pressured to behave like everything is fine and that I don't need to talk because they've set the template kind of thing ... Then there's not much room to go 'Actually, things are really fucked up, I'm not doing well at all. I need a hand.'—Frontline worker
G. Consistent	'I think the big thing is seeing, certainly it's that macro right down to the micro view, where the sector really values clinical supervision, so there's good training available for clinical supervisors. There's good support for clinical workers within the organization to access clinical supervision that's strongly encouraged to do that. I would like to see it where it's compulsory like part of a membership to a professional society.'—Manager

supervision, which were categorised into those for the individual worker and the sector.

For the worker: Participants viewed clinical supervision as beneficial to individual workers for a variety of reasons. Clinical supervision was viewed by participants ( $n = 11$ ) as a form of self-care and participants felt that it helped to reduce stress and burnout (see Table 3, Section A). Participants perceived clinical supervision to increase their confidence in working with clients (see Table 3, Section B). Participants ( $n = 10$ ) described clinical supervision as being important for identifying situations where a worker may enmesh their personal lives with client work, overstep boundaries or become too involved with a client (see Table 3, Section C). Clinical supervision was thought to improve workers' understanding of the therapeutic alliance and how to manage it effectively (see Table 3, Section D). Participants ( $n = 9$ ) felt that clinical supervision taught them new skills and strategies to use in practice (see Table 3, Section E). Participants felt that clinical supervision provided a space for critical reflection on their work, which was often facilitated by hearing another perspective (see Table 3, Section F). Workers described clinical supervision as being helpful for navigating complex client issues, particularly when they may feel 'stuck' ( $n = 11$ ; see Table 3, Section G). Finally, participants also perceived clinical supervision to be important for validating their work (see Table 3, Section H).

For the sector: Frontline workers and managers ( $n = 11$ ) both perceived clinical supervision among AOD workers to be effective in improving the quality of care for clients (see Table 3, Section I). Participants ( $n = 6$ ) also reported clinical supervision to increase longevity of workers in the sector and reduce turnover (see Table 3, Section J).

*Theme four: Barriers and facilitators to accessing effective clinical supervision.* Participants spoke about barriers and facilitators to accessing effective clinical supervision. These were categorised into three sub-themes: logistical barriers and facilitators; supervisor and supervisee matching; and clinical supervision delivery formats.

**Logistics:** Participants cited three logistical barriers to accessing effective clinical supervision. The first of these was financial cost, referring to the high cost of private providers of clinical supervision ( $n = 14$ ; see Table 4, Section A). Second, participants ( $n = 7$ ) cited time as a barrier to accessing supervision, due to heavy workloads and scheduling difficulties (see Table 4, Section B). Finally, participants ( $n = 9$ ) also cited the paucity of skilled AOD-specific clinical supervisors available as a barrier to accessing effective supervision (see Table 4, Section C).

**Matching:** Participants identified several factors upon which they felt the matching of supervisors and supervisees should be based to maximise its effectiveness. Participants ( $n = 12$ ) cited experience as an important factor in matching (see Table 4, Section D). Specifically, workers felt that clinical supervisors should have significantly more professional experience than the worker to whom they are providing supervision. Participants felt that the professional background of both the supervisor and supervisee should align (see Table 4, Section E). Trust and rapport between supervisor and supervisee were identified as important for the effectiveness of clinical supervision (see Table 4, Section F), as were the philosophical paradigms ( $n = 9$ ) of supervisor and supervisee (i.e. abstinence-based, harm-reduction focused; see Table 4, Section G) and expertise and interest of both supervisor and supervisee (see Table 4, Section H). Two participants, including the single participant who identified as Aboriginal, cited culture as a highly important factor in matching supervisors and supervisees for effective clinical supervision (see Table 4, Section I).

**Delivery format:** Participants identified the delivery format of clinical supervision as an important determinant of its effectiveness. They spoke about clinical supervision being delivered one-on-one versus group settings. Overall, participants favoured one-on-one over group clinical supervision, however, both delivery formats were perceived to have potential benefits for workers. Individual clinical supervision was considered to be more tailored to the individual needs of workers and a safer space for workers to openly discuss their work (see Table 4, Section J), while group clinical supervision was considered to sometimes be psychologically unsafe and not necessarily relevant to all supervisees' practice. However, some participants enjoyed and valued group clinical supervision as it made them feel more connected to their colleagues (see Table 4, Section K).

Participants also discussed clinical supervision being delivered by someone who worked within their organisation compared with someone who worked externally. Most participants preferred to receive clinical supervision from an external clinical supervisor, rather than an internal supervisor. Participants reported feeling more comfortable discussing their work with an external clinical supervisor, and found they offered more of an unbiased viewpoint, compared with internal clinical supervisors (see Table 4, Section L). They also found that among external clinical supervisors, there was a greater choice of skills and expertise compared with clinical supervisors who they could choose from internally.

Some participants viewed internal clinical supervision favourably because supervisors had organisational

**Table 3.** Part one, theme three: Benefits of clinical supervision among AOD workers

For the worker	
A. Reduces burnout	'I really highly value supervision and I promote it to anybody if it comes up in a conversation. I think it's incredibly valuable for the work that we do, because it can be draining. It can be exhausting, and having someone to talk to, it just helps you to reset. It's brilliant.'—Frontline worker '... like the old saying, "You can't care for other people if you're not caring for yourself." It really keeps that in check, going to supervision. Making sure that, I guess you're looking after your own wellbeing as well.'—Frontline worker
B. Increases confidence	'I just felt like I was speaking to someone who really knew their shit so I could go there and say, look, this is what's going on with my clients... We would step through it and I'd come out of there with some really good tools and some great knowledge. I'd come out feeling a whole lot wiser. I could manage what was going on. It was awesome.'—Frontline worker
C. Identifies worker issues	'Because we work with such a complex presentations to have good supervision is, is just absolutely necessary. For me to be able to separate what's my stuff and what belongs to me and what belongs to the client.'—Frontline worker 'My supervisor, or the other peers that I work with, have been able to quickly identify when, for example, maybe there's some transference issues going on between a worker and a client, or counter transference, over-identification, people becoming burnt out, people's personal issues getting a little bit of enmeshed with their clinical work.'—Manager
D. Therapeutic alliance	'I think it's just enabled a, perhaps a clearer learning for myself in terms of understanding therapeutic process, understanding relationship, understanding some of the complexities in even establishing and maintaining a therapeutic alliance. It's given me a better insight into that process and the things that can kind of cause some drift or distraction and to be alert to those.'—Manager
E. Skill development	'Not only am I checking myself I'm learning new strategies as well... So I'm learning new tools it's a little bit like, I guess, solution-focused, personal development. You get that training as well in supervision. You can get different tools that they've used and get them by your side.'—Frontline worker
F. Navigating complex issues	'I kept on with her because she could see things that I couldn't see when I was in the mess of everything. She was someone who had nothing to do with the mess and could go, what do you think about this? I'd go, "Oh my God, I never thought about that." Of course, I couldn't because I was down here where everything was happening and she was quite separate from it. That was excellent. Excellent.'—Frontline worker 'I think the old adage of "six heads is better than one", definitely. There are times that ... you can personally reflect on your work but sometimes it just takes saying it to someone else to see a different point of view ... There's a lot of "aha!" moments, massive. How complex the clients we work with are, if I had less, if this level of supervision was less, I think it would actually really dramatically impact the client.'—Frontline worker
G. Facilitates critical reflection	'I think it's helped me be a little more reflective and it's challenged me in a productive way to look at things from a different perspective.'—Manager 'I think especially if there's become a real tunnel vision and that may be you're missing something. You're looking at it from a set way having that external input load, even just the space to reflect with somebody else often it changes what strategy and how you're going to approach things, particularly if you've become stuck. So I think the clients benefit from essentially they're getting a second opinion and a different input.'—Manager
H. Validation	'... It's just helped me to be reassured that I'm doing good work, to just put it very basically. That I'm doing the right thing, I'm helping people, that any mistakes I may make are not the end of the world (laughs). There's always ways to do things differently to learn. It's helped me to feel like there is support. Especially if there is a crisis with a client and I'm not sure if I handled it the right way. I can just have a phone call with the supervisor and have just a quick case consultation. That's really helpful. It's helped me to feel just supported and valued.'—Frontline worker
For the sector	
I. Improves quality of care	'There's a lot of "aha!" moments, massive. How complex the clients we work with are, if I had less, if this level of supervision was less, I think it would actually really dramatically impact the client.'—Frontline worker 'It's helped my organisation and my clients in the way that I'm learning and growing every time.'—Frontline worker
J. Increases longevity of workers	'I think it certainly shaped me. It's enabled me to be resilient enough to stay in the sector for twelve years. I think it's certainly been an important ingredient for that. It's enabled continued development rather than stagnating.'—Manager

**Table 4.** Part one, theme four: Barriers and facilitators to accessing effective clinical supervision

Logistics	
A. Financial cost	‘Funding, funding, funding, funding and funding. Because as I said, it’s an expensive exercise and to be fair, I think there’s a lot of workers out there that can’t actually afford to pay for the level or amount of supervision that they really should get to really support their work.’—Frontline worker ‘I think ideally if we could get a once a month paid clinical supervision, everybody would definitely benefit because I know there’s quite a few people who get their supervision because they can’t afford the out-of-pocket. Personally I can’t afford not to.’—Frontline worker
B. Time	‘I think time is one of the factors, certainly in the not-for-profit sector there is not a lot of room in people’s workloads to attend supervision—often it gets pushed back as the last priority.’—Manager ‘I think scheduling is an absolute nightmare. If you actually go face-to-face, it is, I’ve got to drive into the city, so travel has to be included in the time that we’re going there as well. Then if you’ve got crises happen, sometimes they happen last minute, you’re cancelling, then you get frustration on the other end because it’s like when do we reschedule for, so with conflicting calendars sometimes it’s super difficult.’—Frontline worker
C. Availability of skilled supervisors	‘Availability. Because that’s the barrier that’s hindering me from being able to get it. So just no availability, capacity and wait lists and stuff like that. That’s kind of what’s getting—the barrier that’s kind of in the way for mine at the moment... It’s just like availability, and the number of clinical supervisors in comparison to the number of people wanting clinical supervision.’—Frontline worker
Matching	
D. Experience	‘I guess I would have issues being supervised by someone who’s only been in the industry or the field for five years when I’ve been in industry for 20–30 years. What are they going to teach me?’—Frontline worker
E. Professional background	‘I guess one of the other challenges for me has been trying to, because I’ve come out of social work, I tend to try and find social workers to provide that supervision, and I haven’t always found that possible.’—Manager ‘... because my background is quite diverse in terms of experience and CALD [culturally and linguistically diverse clients] and all that sort of stuff, I’ve found it difficult to find a clinical supervisor that has, I guess a similar background and understanding of different areas... We’re an AOD service, but we deal with such a gamut of presenting issues so to find someone that can work alongside and provide that guidance and everything has been quite difficult.’—Manager
F. Trust and rapport	‘And then I think when you’re looking at something like the supervision relationship, there’s got to be some level of personality match... there’s got to be a sense of trust and rapport there.’—Manager ‘We don’t criticise our clients. We don’t pressure our clients. I think there’s no place for that in clinical supervision either. It’s about how people can grow and learn. We can make mistakes, if we feel safe that we can share that in supervision and... feel trust in our supervisor, I think that would be ideal.’—Frontline worker
G. Philosophical paradigm	‘I feel that having similar frameworks is useful. Someone who is in, say, a rehab might not find as useful, engaging with someone who’s in a needle syringe program due to value clashes and things like that. And saying that, there are some excellent people in both models that would provide excellent supervision no matter what. It comes down to preference.’—Frontline worker
H. Expertise/interest	‘If you’ve got a supervisor that has maybe only ever worked with a mid-intensity or low-intensity client, they aren’t going to be able to offer the richness that another supervisor who’s worked with real complexity and a broad range across AOD would be able to offer when you’re working with those complex clients.’—Frontline worker
I. Cultural background	‘I think culture’s really important. For example, as an Aboriginal woman... I would feel more comfortable with a female supervisor because I could talk about issues, all issues. With a man, I would probably fall back on some things around my clients, cause I wouldn’t be comfortable talking to a male about certain frameworks of practice. You know, women’s’ business, stuff like that. I think culture has to come into it... I think that’s a big part of it. I think that needs to be taken into consideration... I think the culture, it is really hard to find culturally appropriate clinical supervision. That really is, and I think that that is an area that needs to be tapped into and looked at for those workers who are working within an indigenous framework because we do operate a little bit different. Like we, the cultural factors is a big part of what we do and that’s not always understood by mainstream clinical supervisors I’ve had experience with, they don’t understand what culture means, what that connection is, and that incorporates into our work as practice and not understanding that. I think that’s a big gap.’—Frontline worker

(Continues)



Table 4. (Continued)

Delivery format	
J. Individual	<p>'I guess it's probably more tailored to an individual's skillset areas that they're working on. Obviously you get more time and focus in space to talk about what's going on for you. And I think there's probably a little bit of a barrier in a group setting to sometimes be as honest or as open about some of the challenges compare to individual.'—Manager</p> <p>'I think most organisations would prefer to provide individual supervision with their staff if they could afford it.'—Manager</p>
K. Group	<p>'There's obviously pros and cons to both. I think there's some benefits in the group supervision about learning off each other and sharing some knowledge and resources. But personally I've found the individual supervision more valuable.'—Manager</p> <p>'I feel that the onsite one doesn't meet any of my needs. I don't feel comfortable attending the onsite one. Because of the relationship between me and the workers. I work from harm reduction/minimization, they work more from an abstinence framework. It's always about the people here on the program, and that doesn't meet my needs because I work with people in the community. They're focused more about this place and that's not where I work. Even though I'm employed here and I'm part of the team, I just, it doesn't fit, and also I don't get anything out of it.'—Frontline worker</p>
L. Internal	<p>'I think what hinders it is, well for us, being drug and alcohol services, in a service that provides, or in an organization that provides, a vast array of non-alcohol and other drug services. My manager, her background is in policing. Another manager of mine also manages the retail shops, so they don't have any experience in alcohol and other drug treatment. I think that's a really, really big barrier.'—Manager</p> <p>'The biggest bonus of that is I don't have to pay for it. Obviously that's the biggest bonus, is cost. Probably the biggest downfall or challenge is that we have personal relationships.'—Frontline worker</p> <p>'It's been everything from unhelpful to quite traumatic actually... I've had supervision where I didn't feel that I could trust the supervisor. The supervisor was also the line manager... Anytime I've had supervision delivered by a line manager... I've felt under pressure. I haven't felt valued. I've felt almost disrespected at times. I felt pressured to meet KPIs or haven't trusted the person... I haven't trusted the people to share what I've really been concerned about in my work.'—Frontline worker</p> <p>'Trying to find another social worker who specialized in that field was really challenging and it always ended up being my line manager and that dual relationship just can't work well for me as a supervisee. It can't because even though she's very non-judgmental, you know, it'd be fine if I discussed stuff with her. For me that was a barrier. I couldn't tell her everything because it was that fear of—not repercussions—but be embarrassed that I didn't to ask that question or talk about that sort of stuff.'—Manager</p>
M. External	<p>'External supervision is where I like to talk about transference, counter transference. You can talk about that at external supervision or supervision obviously from this organization, but I find that it's a safe space to talk about ... more about myself as a person rather than myself as a worker. So that can be a little bit more personal.'—Frontline worker</p> <p>'... My current supervisor... because she's not directly involved in my day to day practice, I could just go there and tell her anything and sit there and cry ... and there's no fear of that impacting my day to day work because she is removed.'—Manager</p> <p>'We do have somebody within the organization that I can seek supervision from. I guess I just found I was a little bit uncomfortable with her. It was a little bit harder to discuss like little personal things that may come into supervision as well. So I do outsource my supervision once a month.'—Frontline worker</p>

contextual knowledge and were usually more familiar with the particular service's client base. However, internal clinical supervision for the majority of participants was viewed as less psychologically safe, particularly when internal clinical supervision was delivered by workers' direct line managers (see Table 4, Section M).

#### *Part two: Perceived barriers and facilitators to implementation of a clinical supervision exchange model*

Frontline workers and managers' views of a clinical supervision exchange model were explored in part two

of the interview. Two consistent themes emerged from the analysis: (i) perceptions of a clinical supervision exchange; and (ii) potential barriers and facilitators to effective implementation. Relevant quotes for each theme and sub-theme appear in Table 5.

*Theme five: Perceptions of a clinical supervision exchange.* Participants viewed the implementation of a clinical supervision exchange model in the AOD sector favourably for several reasons. Participants ( $n = 10$ ) felt that implementation of such a model would likely increase access to external clinical supervision (see Table 5, Section A). They also felt that a

**Table 5.** Part two, themes five and six: Perceptions of a clinical supervision exchange

Theme one: Perceptions of a clinical supervision exchange

A. Increase access to clinical supervision among workers	‘The benefit is accessibility. It might be more accessible which is at least a good start because I know that there is not a lot of really good access to supervision now, not enough.’—Frontline worker ‘That’s a great way, like, to increase access, utilizing the resources you’ve already got, so they’re utilizing the people that are already there. I definitely think, as I said, if people feel they have the capacity and knowledge to be able to do that, then I think that’s a great idea.’—Frontline worker
B. Expose workers to greater diversity of perspectives	‘I think it exposes the worker to varied ways of thinking about things and because, particularly when supervisors work for a certain organization, you embed, you kind of embed that organization’s values and ethos and procedures in your mind which can get carried into that direct operational supervision with people in the same organization. But when you’ve got an outside picture, it kind of comes from another angle. I think there’s a lot of value in that.’—Manager
C. Low monetary cost	‘I’d say I see mostly benefits because it’s just an opportunity that sounds like wouldn’t be cost prohibitive.’—Manager ‘Having access to supervision whether you take it or not is really vital in this area. Like AOD is kind of the poor second cousin to mental health... I see it going well for the employers to be able to afford, and allowing it to happen basically.’—Frontline worker
D. Increases sector collaboration	‘I do think it’s a really good opportunity for us to share knowledge, share the resources and I think it’s a way to connect the sector even better because I think through that supervision, those supervision relationships... like the learnings that can come from that I think could be incredibly rich. I just think it bolsters the sector, it’s people working together to work for better outcomes for the clients that we work with. I just see it being a huge benefit.’—Manager
E. Increases perceived value of clinical supervision	‘I think it will have the effect, I think across the sector of really raising the value of clinical supervision. I think that’s an extremely good thing, because that’s certainly something I value and something that I think the sector has not really grabbed and been able to roll out in a way that’s been effective.’—Manager

Theme two: Potential barriers and facilitators to effective implementation

F. Matching	‘... Or you got someone who just totally didn’t match. If you match an organization that’s harm reduction with one that’s abstinence based and there’s just this real mismatch of overarching frameworks.’—Frontline worker
G. Competitive tendering process	‘On the flip side, all of a sudden is your IP getting shared around? And all of a sudden it’s another one of going ‘whoa, oh, that’s a good way of doing it! We’ll go and start doing that’ You’re like, well, hang on... because at the end of the day, sometimes we’re all going for the same funding. Everyone’s all nice until the money starts to run out. We’re trying to fight for the same scratch at the table.’—Frontline worker
H. Confidentiality	‘I guess the confidentiality’s the first thing that springs to mind. That there would be organizational confidentiality as well as the client confidentiality.’—Frontline worker ‘I don’t know what it is about AOD services where like, you know, ‘I don’t like you, you got our funding’, but it’s, get over it, move on. That’s I guess the issue that stands out the most is that the confidentiality would need to be spot on.’—Frontline worker
I. Flexible delivery modes	‘So having people that are close and will meet them somewhere and it doesn’t take a lot of time out with travel and transport, and having those private Skype sessions is something that is very important. I guess flexibility on the delivery.’—Frontline worker
J. Additional time cost	‘The extra time that that will take team leaders. So they’ll still need to manage their own team and someone will be swapped and go somewhere else for supervision. But I do think as a whole that is going to cost time for that team leader. I don’t think it’ll work out perfectly. Of course it never does. So I imagine increased workload is probably the only disadvantage I see.’—Frontline worker
K. Training	‘Is there going to be like, some stock standard training for the people who are providing the supervision?... I think that’s going to be a good idea because then everyone’s in the same playing field, this is the expected standard. Obviously, it’s going to look different, some of the supervisors’ interpretation of it, but I do think that there needs to be that baseline.’—Manager
L. Governance	‘I think there is going to have to be really clear structural guidelines around those types of things and how it’s managed. How there’s equity across services and their access versus how much they’re providing to the system or the exchange. What to do if there any issues do arise and how that’s managed. Even going back to discussions about what a supervisor may discuss with a line manager, about what arises in supervision... just being very clear around how that’s all set up would be quite important I imagine.’—Manager

(Continues)

Table 5. (Continued)

## Theme two: Potential barriers and facilitators to effective implementation

M. Value of clinical supervision	'Employer bias, like it can be seen as a bit of a, if you haven't got a good understanding of why clinical supervision is important, it could be difficult when you're trying to make numbers up and stuff like that. Taking away from hours that you can provide support, but at the same time it's giving back, but it's understanding that. I think the biggest barrier is the understanding of the importance of it... And I mean you can tell people how important clinical supervision is but until they see it themselves they probably don't understand it. So it's going to be really hard to get them to buy in and do it, without a bit of motivation. Especially some of these people are so busy. It's like they already have to fit so much into their time and how they are going to be able to do that.'—Frontline worker
N. Sustainability	'But I think one of the challenges will be to make something sustainable, it does depend on people's capacity to buy into it, and then to feel the benefit in the short term but also the long term for organisations. Because ultimately for organisations, the value of it will be for their organisation I guess. I think—and how to kind of see it as a sector thing, and as a sector we're... the sector still does feel fairly fragmented. Anything that kind of helps bring the sector together, any common basis like this where we're working together—but it's a bit chicken and the egg because if you then start a good clinical supervision process, hopefully that leads to a more united sector. But yeah I think issues around sustainability, you could argue that, but hopefully it creates stability.'—Manager

clinical supervision exchange would expose workers to a broader range of perspectives across the sector ( $n = 10$ ; see Table 5, Section B). Participants felt that implementation of the model was likely to be cost-saving and would increase collaboration across the AOD sector (see Table 5, Sections C and D). Participants also felt that implementation of a clinical supervision exchange model would increase the perceived value of clinical supervision among workers (see Table 5, Section E).

*Theme six: Potential barriers and facilitators to effective implementation.* Participants identified several potential barriers and facilitators to effective implementation of a clinical supervision exchange model in the AOD sector. The first, but not necessarily most important barrier was matching supervisees with supervisors from different professional backgrounds, treatment service types and philosophical paradigms (see Table 5, Section F). The competitive tendering environment and risk of intellectual property loss to other services through clinical supervision was considered to be a deterrent to participation in a clinical supervision exchange (see Table 5, Section G). Confidentiality at both the client and organisation levels was considered paramount to the success of the model (see Table 5, Section H). Flexible delivery of clinical supervision was viewed as important to the effectiveness of a clinical supervision exchange, particularly for regional, rural or remote AOD workers (see Table 5, Section I). Participants ( $n = 7$ ) felt that participation in a clinical supervision exchange would demand additional time resources from AOD services (see Table 5, Section J).

Training of supervisors and supervisees was considered important to the success of a clinical supervision exchange (see Table 5, Section K). Participants identified a need for good clinical governance processes to ensure that any problems or issues between services or workers could be appropriately managed and resolved to support sustainability of the model (see Table 5, Section L). Participants felt that the degree to which AOD workers and service managers value clinical supervision would determine participation and sustainability of an exchange model (see Table 5, Sections M and N).

## Discussion

This study aimed to examine perceived barriers and facilitators to: (i) accessing high-quality clinical supervision among AOD workers; and (ii) effective implementation of a clinical supervision exchange model in the AOD treatment sector. A total of 21 AOD workers from eight organisations across the government and non-government sectors participated in the study. This included 10 frontline workers and 11 managers, with a range of professional backgrounds and experience in the AOD sector (ranging from 4 months to 30 years).

Six consistent themes were identified among frontline workers and managers. The first of these was a perceived need for AOD workers to receive clinical supervision from AOD treatment specialists. Consistent with previous research in medical and allied health-care settings, clinical supervision was considered to be an effective strategy for reducing stress and

burnout among AOD workers [31]. Participants perceived the AOD workforce to experience high rates of stress and burnout due to heavy workloads and the incidence of vicarious trauma, consistent with previous findings [32–34]. Lived experience of AOD use among the workforce was also viewed as a contributor to stress and burnout. This is consistent with evidence suggesting that these workers are more likely to report discrimination in the workplace and have less social support outside of work, which raises the potential for additional risks to well-being [35]. Participants also identified isolated working conditions among outreach workers as a risk factor for worker burnout, consistent with previous qualitative research suggesting that outreach AOD workers have less access to peer support [36].

Participants also felt that the provision of clinical supervision to AOD workers requires specialist knowledge of AOD treatment delivery due to several factors previously identified in the literature, including the complexity of client cases [17,18], unique and varied treatment needs of people accessing services [37] and stigma and discrimination affecting people who use drugs [38,39]. Unrealistic societal expectations placed on the sector to produce positive outcomes were perceived to necessitate the provision of clinical supervision to AOD workers from an AOD specialist. This is consistent with previous research among a sample allied health professionals including psychologists and social workers, which suggested that clinical supervision was perceived to be more effective when a supervisor had expertise in the supervisee's field [40]. Evidence suggests this perception is shared by workers in other health-care professions such as midwifery, psychology, counselling and nursing [41–44]. As the AOD workforce comprises practitioners with a great diversity of professional backgrounds, the capacity to match supervisors and supervisees based on both AOD specialist knowledge and professional backgrounds could be challenging [45].

Frontline workers and managers had a shared understanding of what constitutes good clinical supervision, consistent with Proctor's [46] three-function model which suggests clinical supervision should support skill development, worker well-being and accountability to professional standards. Participants also felt that clinical supervision should provide a psychologically safe environment for workers to openly discuss their work without fear of judgment or repercussions. Operationally, participants were of the view that all AOD workers whose roles are client-facing should receive regular clinical supervision at least monthly. Participants also felt that supervisors and supervisees should receive clinical supervision training to ensure the consistency and quality of clinical supervision provided across the sector. There was also an identified need

for AOD workers across the sector to be supported by organisations to receive high-quality clinical supervision. While clinical supervision requirements for health-care professionals vary between jurisdictions and disciplines, these conceptual and operational issues are key features of effective clinical supervision in national and international supervision guidelines [3,4,47].

Clinical supervision was considered to have a range of benefits for individual workers, the services in which they work and their clients. Consistent with previous research, participants viewed clinical supervision to be effective in reducing burnout [8,9], developing skills [48,49], improving the therapeutic alliance [11] and increasing worker confidence [50,51]. In addition, participants perceived clinical supervision to facilitate early identification of quality of care issues, improve a worker's ability to navigate complex client cases, create opportunities for critical reflection and validate the profession. Participants were of the view that clinical supervision could improve quality of care, consistent with findings in medical and allied health-care settings [52]. Participants also felt that clinical supervision increases the longevity of workers in the AOD sector, consistent with research which found that clinical supervision was negatively associated with turnover intention among AOD counsellors [6].

Participants identified a range of factors that they perceived to be barriers and facilitators to AOD workers accessing effective clinical supervision. These were categorised into three sub-themes: logistical factors, matching factors and delivery format. Limited time, the high cost and low availability of skilled external supervisors were identified as the primary logistical barriers to accessing supervision. These findings are supported by previous research identifying that AOD treatment services in Australia are chronically under-funded and over-stretched [53]. Originally, the researchers categorised perceived barriers and facilitators to accessing effective clinical supervision into individual-, organisational- and systems-level factors. However, several barriers and facilitators were found to not necessarily fit neatly into one of those categories. For example, the high cost of private providers could arguably be considered an individual, organisational or systems-level barrier to accessing effective clinical supervision. This may also suggest that the most effective strategies to address some of these barriers must also be targeted towards supporting individual workers, their organisations and the AOD treatment service system.

Factors relating to the matching of supervisors and supervisees were viewed as important to the effectiveness of clinical supervision, including professional experience, professional background, trust and rapport, philosophical paradigms, expertise, interests

and cultural background. Previous research among family therapists suggests that it is the supervisory relationship itself, specifically the working alliance, which leads to supervisee satisfaction with supervision rather than necessarily individual contextual or methodological variables of the supervisor or supervisee and how they match up on those characteristics [54]. Together, these findings suggest that there is a need for further research examining the importance of supervisor-supervisee matching on clinical supervision satisfaction and effectiveness among AOD workers.

Participants also viewed different modalities of clinical supervision (i.e. group, individual, internal, external) to have slightly different functions and showed a preference for receiving individual, externally delivered clinical supervision. Previous research has suggested that external clinical supervision is more effective than internal supervision as it helps to ensure that the roles of clinical supervisor and appraiser are separate [23].

Several of the perceived barriers and facilitators to AOD workers accessing effective clinical supervision may be more simply addressed than others. For example, matching of supervisors and supervisees based on particular characteristics is possible to some extent, but limited by the availability of skilled clinical supervisors in the sector. The majority of perceived barriers and facilitators could be addressed through increased investment in the provision of clinical supervision to AOD workers. For example, cost, time and availability of skilled supervisors could be directly improved through significant investment in training and workforce development which in turn, would increase capacity for effective supervisor-supervisee matching and access to external clinical supervision. Frontline workers and managers were asked about their views of a clinical supervision exchange model for AOD workers and to identify potential barriers and facilitators to its implementation in the AOD sector. Participants perceived implementation of the proposed clinical supervision exchange model to be a resource-effective strategy for increasing access to external, individual clinical supervision while also exposing workers to a greater diversity of perspectives, increasing sector collaboration and improving the perceived value of clinical supervision among the workforce. Perceived potential barriers to effective implementation of the model were related to: matching of supervisors and supervisees; the competitive tendering process that may deter services from wanting to collaborate; risks to confidentiality and intellectual property; the possible additional burden placed on resource-stretched services; and sustainability of the model. Participants also considered it important that participating supervisors and supervisees receive training, and that a governance framework is developed to support resolution of conflicts or issues.

This study has several limitations. One of these is that the participant sample was not representative of all frontline workers and managers employed by AOD treatment services and only one participant identified as Aboriginal or Torres Strait Islander. Attraction, support and retention of Aboriginal and/or Torres Strait Islander AOD workers in Australia is essential to ensuring provision of culturally appropriate care for the disproportionate level of AOD harm experienced by Aboriginal and/or Torres Strait Islander peoples [55]. As a result, there is a need for future research examining barriers and facilitators to accessing effective clinical supervision among Aboriginal and/or Torres Strait Islander AOD workers. The results of this study are also constrained by participants' understanding and knowledge of sector issues. Frontline workers and service delivery managers are unlikely to have an overview of systems-level issues and therefore barriers and facilitators identified in this study are likely to be predominately at the individual worker and service levels. Therefore, a gap exists in identifying systems-level barriers and facilitators to implementing a clinical supervision exchange model in the sector.

The findings of this study cannot be generalised to other settings or populations. However, it is conceivable that AOD workers in other metropolitan areas in Australia would share similar perceptions of the barriers and facilitators to accessing effective clinical supervision and implementing a clinical supervision exchange model. Across Australia, there is evidence of limited access to individual, external clinical supervision among the AOD workforce [16], and the sector is over-stretched and under-funded across states and territories [53]. Non-government AOD treatment services in Australia are also purchased largely through competitive tendering processes across states and territories [56]. Future research examining barriers and facilitators to accessing effective clinical supervision among AOD workers in regional, rural and remote areas would be valuable.

## Conclusion

This study identified perceived barriers and facilitators to workers accessing effective clinical supervision and implementation of a clinical supervision exchange model in the AOD sector. Primary perceived barriers to accessing effective clinical supervision among frontline workers and service managers included the cost of providers, and the lack of time and availability of skilled supervisors. These findings have important practical implications for policymakers to inform how access to effective clinical supervision among the AOD workforce can be improved. The consistency in themes

between managers and workers around the need for specialist AOD clinical supervision, and preferences for how it is delivered, is promising, and highlights the need for a sustainable model of clinical supervision that addresses the primary barriers. Implementation of a clinical supervision exchange model was perceived by frontline workers and service delivery managers to be a resource-effective strategy for addressing these barriers and increasing access to high-quality clinical supervision among workers. The results of this study have informed the development of a clinical supervision exchange model which is currently being trialled among six treatment organisations in the government and non-government AOD sector in Queensland.

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### Conflict of Interest

CO is supported by QNADA to undertake her PhD. This project was funded by the Brisbane North Primary Health Network (BNPHN). The clinical supervision exchange model was developed by QNADA. NL is the founder and CEO of 360 Edge who led the co-development of AOD supervision training and resources with QNADA.

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## Supporting Information

Additional Supporting Information may be found in the online version of this article at the publisher's website:

**Appendix S1.** Semi-structured interview questions.