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Interprofessional supervision:

Mapping the interface between professional knowledge, practice imperatives and difference.

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Abstract

The purpose of this doctoral study was to explore interprofessional supervision as a mode of professional supervision practice and to consider how the participants of this supervision understand, construct and manage the interprofessional processes and relationships. It is clear from a review of national and international literature that increasing numbers of professional practitioners participate in interprofessional supervision arrangements but that to date this form of supervision has not been extensively investigated. The research contributes to the knowledge base of interprofessional supervision practice through the exploration, description and mapping of the attributes, processes, skills and structures which underpin this practice, with particular attention to the management of difference.

This qualitative research, which had four phases, was located in Aotearoa New Zealand. Phase one identified the broad regulatory and professional context for interprofessional supervision while phases two and three explored how expert informants (participants who had training and experience in supervision and who were currently in an interprofessional supervision arrangement) experienced and practised this mode of supervision. In phase four a ‘framework of interprofessional supervision’, developed from the findings of phases two and three, was presented to the original participants of phase two who were invited to provide feedback. The responses of the participants shaped the construction of a Map for Interprofessional Supervision. This map provides detail and parameters to this form of supervision and offers a template to guide those who are engaged in, or who wish to engage in, supervision with someone from a different profession.

Key elements which underpin the Map for Interprofessional Supervision demonstrate that: interprofessional supervision is a practice in its own right which requires training and expertise; participants in interprofessional supervision work within the dual perspective of professional identity and identifying as a professional; and interprofessional supervision is an aspect of interprofessionality with three distinguishing features: membership, choice, and negotiated relationship. Finally a Diversity Model of interprofessional working is presented. Here interprofessional supervision, as an example of this model of interprofessionality, demonstrates that diversity, when chosen and valued, can clarify and reinforce professional identity and knowledge whilst at the same time be a catalyst for the development of new insights, new knowledge and new expertise.

Acknowledgements

To all the people from different professional backgrounds with whom I have worked as a supervisor, supervisee, trainer, educator and as a manager I owe a debt of gratitude. Through their willingness to journey with me and to explore the often uncharted boundaries between professions we found learning for us all and established what for me, has been an abiding interest in working at the professional and interprofessional edge. I also want to thank all of the participants in this doctoral study who have been generous in sharing their time and their thoughts, experiences, practice and critique. Together we have developed the map for interprofessional supervision, and their contributions have shaped the Diversity Model of interprofessional working, which provides a new understanding how diversity can bring people together.

No acknowledgement is complete without recognition of the support and encouragement provided by the doctoral supervisors. To Christa and Liz I give my thanks for all the wisdom, knowledge and the perspectives they shared, for their excellent feedback, their challenging and thoughtful comments and questions, and ultimately, for their faith in me.

Finally to my family: to David, Gen, Sebastien and Mike, my thanks for once again supporting and encouraging me to retreat and to write.

Postscript.

On March 15th 2019, whilst I was in the process of finalising this document, fifty one Muslim worshippers were massacred in Christchurch New Zealand. The following weeks have brought grief, soul searching and pain to New Zealand as a nation and the phrase “this is not who we are” has been defining of the nation’s response. Knowledge of who we are, Simon Wilson (2019) says in a reflection on this tragedy, allows us to reveal ourselves to others. “To know trust. To revel in the excitement, to worry at the confusion and to relish the rewards that come from discovering the lives of others. The richness of living amid diversity and the pleasures of it. And the safety too, that comes when you understand we are friends.”

I hope that this research contributes in some small way towards a welcoming and celebration of diversity.

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Chapter 1: Introduction

Supervision, “the worker’s most important relationship” (Morrison 2001, p. 3) is a professional activity which is central to the work of those engaged in the health, psychological and social service sector professions.

Žorga (2002) provides the following definition:

Supervision is understood as a specific learning, developmental and supportive method of professional reflection and counselling, enabling professional workers (school counsellors, teachers, child care workers, psychologists, social workers, etc.) to acquire new professional and personal insights through their own experiences. It helps them to integrate practical experiences with theoretical knowledge and to reach their own solutions to the problems they meet at work, to face stress efficiently and to build up their professional identity. By this, supervision supports professional as well as personal learning and development of professional workers. (p. 265)

For many practitioners, who are employed in the health, psychological and social service sector professions, professional supervision is mandated by professional and/or regulatory bodies and traditionally has been required to occur between two people from the same discipline or profession (Bernard & Goodyear, 2009; Bogo & Paterson, 2015; Hair, 2013; O’Donoghue, 2004; Priddis & Rogers, 2018; Townend, 2005). *Interprofessional* supervision where the supervisor and supervisee do not share a professional background, has grown however in prevalence and acceptance over the past two decades (Beddoe & Howard, 2012; Bogo & McKnight, 2006; Carroll, 2014; Crocket, Cahill, et al., 2009; Hair, 2013; Hutchings, Cooper, & O’Donoghue, 2014; Kelly & Green, 2019; Launer, 2018; Noble, Gray, & Johnston, 2016; Townend, 2005). To date there has been little research into this form of supervision practice (Bostock, 2015; Chipchase, Allen, Eley, McAllister, & Strong, 2012; Hutchings et al., 2014; O’Donoghue, 2004; Townend, 2005).

The Research

The primary aim of this study is to explore, describe and map the ways in which the participants of interprofessional supervision work with each other and engage in supervision practice. Two sets of secondary questions are considered.

1. What values, knowledge and beliefs about professional supervision underpin the decision by health, psychological and social service practitioners to engage in interprofessional supervision? What incentives and choices affect this decision?

2. How is interprofessional supervision organised, structured and conducted and how is difference identified, managed and employed within these interprofessional relationships? How do participants of interprofessional supervision describe the difference between interprofessional supervision and same-profession supervision?

Geographically located in Aotearoa New Zealand, and situated in a broad context across five different professions, the research is underpinned by a social constructionist epistemology and employs qualitative methods within a sequential design.

The research was conducted through four phases. Phase one comprised interviews with representatives of regulatory and/or professional bodies and the examination of the supervision policy documents of those professions and examination of relevant legislation. Interviews with expert informants in phase two, (current participants in interprofessional supervision who hold a supervision qualification or who have experience and training in supervision), informed the development of a set of characteristics which describe their reported practice of interprofessional supervision. These characteristics were viewed against, and matched to, the findings from an analysis of recorded ‘live’ interprofessional supervision sessions in phase three. From these two sets of data a framework of interprofessional supervision was constructed and, in phase four, this framework was presented back to the original expert informants of phase two who were invited to provide feedback. From this collaboration a Map for Interprofessional Supervision was constructed. The study design is fully described in the discussion of methodology in chapter four.

The Contribution of this Research

As described earlier interprofessional supervision, though an increasingly common practice (Bostock, 2015; Crocket, Cahill, et al., 2009), has yet to be fully explored (Chipchase et al., 2012; Hutchings et al., 2014; O’Donoghue, 2004; Townend, 2005). Bostock (2015), who ventures to suggest that “it is an area where practice is ahead of the research; few studies have investigated how best to deliver effective supervision across disciplinary boundaries” (p. 15) joins the call for further work and investigation in this area (Beddoe & Howard, 2012; Berger & Mizrahi, 2001; Crocket, Cahill, et al., 2009; Townend, 2005). In particular a need has been identified for guidelines for the establishment of interprofessional supervision relationships and a framework for practice (Bogo, Paterson, Tufford & King, 2011; Hutchings et al., 2014; Simmons, Moroney, Mace, & Shepherd, 2007). A lack of empirical examination of interprofessional supervision practice has also been noted (Bogo & McKnight, 2006), while O’Donoghue and Tsui (2013) comment that much supervision

research relies on ‘retrospective accounts’ (p. 12). This research approaches interprofessional supervision in two ways.

First, the research considers interprofessional supervision as a mode of supervision practice in its own right. The expert informants, whose perspectives and practice are explored in the research, were selected on the basis of their experience in interprofessional supervision practice, not because of their membership of a particular profession or practice context.

Second, the research includes observation of ‘live’ interprofessional supervision and thereby provides an opportunity for consideration of interprofessional supervision practice in ‘action’.

The Map for Interprofessional Supervision, created in collaboration with the research participants, specific though it is to the parameters of the supervision experiences of these research participants, provides a starting place for discussion, debate and hopefully for some unity regarding an understanding of interprofessional supervision. It will assist those currently engaged, and those wishing to engage, in the practice of interprofessional supervision by providing examples of how effective interprofessional supervision is approached, negotiated and practiced. In this manner the research makes an important contribution to this emergent field of supervision practice and begins to address some of the identified gaps in the extant research.

The consideration of interprofessional supervision as an aspect of interprofessional working is an additional contribution of the research. The Diversity Model, developed as an interpretation of the research findings, opens new perspectives on interprofessional work. Interprofessional supervision, as working example of this model, demonstrates that diversity when chosen, negotiated and celebrated can bring new and creative insights and collaborative ways of working which strengthen rather than diminish professional identity.

The Researcher – A Positioning Statement

All research necessarily starts from a person’s view of the world, which is itself shaped by the experience one brings to the research process. (Grix, 2002, p. 179)

I was born in Aotearoa New Zealand but my childhood and teen years were spent living with my family in various parts of the world which included Australia, Greece and England. Difference was always a factor when moving around the world as a child, particularly in school settings. One year whilst attending a French school in Greece, I counted children from more than twenty different cultures or ethnicities in my class. Here I found, as I did in

other situations, that difference was variously experienced as a barrier to belonging, an exotic feature which made me stand out and as a place from which to find similarity and learn from others who also had 'exotic' features.

Graduating with a degree in social work from the University of Sydney in Australia I came back to Aotearoa New Zealand where I have lived and worked ever since. Returning to Aotearoa New Zealand brought the familiar experience of being different but also posed more difficult questions which were 'who am I and where do I belong'? This existential moment has long been resolved but resolution brought the understanding that who I am is not solely defined by belonging to a country, to an institution or to a profession but rather, who I am is shaped by values and beliefs and relationships. This understanding, which has been tested and challenged and has developed over the years, has nevertheless shaped much of my subsequent professional practice as a social worker, as an educator, supervisor and as a manager.

My exploration of interprofessional supervision began in the mid-1990s when I was asked to provide a day of supervision training to a multidisciplinary community health team. At the time I was already teaching supervision skills and theory to social workers and so while the content of such a session was familiar I was challenged (and excited) to move from the comfort of my own profession to a group of people who brought different professional backgrounds. To my relief and delight the day went well and I was struck by the interest, enthusiasm, focus and the new and different perspectives brought by this mixed group. Around the same time I arrived, as a new employee, in a different community health organisation. The nurses there had decided they wanted to have supervision and seized on my background in this area. Stepping into the deep-end I found myself in supervision relationships with a number of these very dedicated and passionate health professionals.

From this beginning I bring to this research more than twenty five years of engagement in interprofessional supervision and interprofessional working. During this time I have been involved in interprofessional supervision partnerships as both supervisor and supervisee, have run supervision training and education with mixed profession groups, conducted interprofessional supervision research and published on this topic and on supervision in general. For over six years, within a polytechnic institute, I managed a school where professional qualifications were delivered for a range of professions (counselling, midwifery, nursing and social work). These qualifications were taught by staff who belonged to those professions. These experiences have developed and honed a keen interest and belief in interprofessional supervision (and interprofessional working) and, building on my early

experiences, a valuing of the benefits which come from embracing, struggling with and negotiating difference. I believe that good relationships, where all voices are heard and valued, are central to managing difference.

My understanding of professional supervision has also been influenced by the writing and research of others. Particular scholars and experts who have inspired and shaped my thinking include Michael Carroll, Peter Hawkins, Robin Shoheit, Joyce Scaife, Meg Bond, Stevie Holland, Bridget Proctor and Tony Morrison. Representing a range of professions, these experts do not necessarily agree on all aspects of supervision. What is common to all of these people, however, is that supervision is supervisee led, it is ethical and accountable, and rests on a constructive, negotiated supervision relationship. Most importantly supervision is considered by these people to be about reflection and learning. From this, my personal definition describes professional supervision as “a forum for reflection and learning ... an interactive dialogue between at least two people, one of whom is a supervisor. This dialogue shapes a process of review, reflection, critique and replenishment for professional practitioners” (Davys & Beddoe, 2010, p. 21).

This definition of professional supervision provides an important baseline for the research. It allows a distinction to be made between what is understood as *professional* supervision and what is understood as *clinical* supervision. In contrast to professional supervision, as defined above, clinical supervision, as I employ the term, is a formal relationship between two people (usually from the same profession) where the skills, knowledge, techniques, interventions and applications specific to the supervisee’s profession are the focus of discussion, reflection and critique.

The background presented here informs and provides context to the research questions and the manner in which the data has been examined as well as shaping a number of assumptions which are brought to the research. It is assumed that the practice of interprofessional supervision is an organised professional activity which has structure, process and skills which are particular, but not necessarily exclusive, to this mode of supervision. The research rests on the premise that ‘difference’ will be a constant factor in interprofessional supervision and that the supervision relationships and arrangements will reflect a process for the management of this difference. It is assumed that the participants in the research will have an understanding of what supervision is, will value supervision and that their beliefs and expectations of supervision, and indeed their approach to all their professional work, will embrace a concept of learning and critical reflection.

The research is located in, and specific to, Aotearoa New Zealand. Whilst the principles and processes of interprofessional supervision practice, it is believed, will be similar across international borders, I agree with Cooper (2006) who argues that attitudes, values and expectations are shaped by local context. In Aotearoa New Zealand health, psychological and social service practitioners are subject to specific and particular legislation and regulation which influence both attitudes and access to professional supervision.

The Professions

This research concerns interprofessional supervision and it is helpful to begin with an understanding of how the term profession is understood in the research. The term profession, often loosely used “synonymously with ‘occupation’ to refer to the job someone does, or a recognised type of work” (Banks, 2004, p. 17) is accompanied by considerable debate, both as to the use of the term and to its meaning. The debate in turn hinges upon which theory of professionalism is applied and in which country the term is being discussed (Banks, 2004). Banks identifies three approaches to the study of professions: the essentialist, the strategic and the historical/developmental (pp. 19–21). The first, the essentialist, sometimes referred to as the trait approach, provides a list of characteristics against which a ‘profession’ is measured to determine eligibility. As Banks elaborates however there is little agreement amongst scholars as to which characteristics apply and to what extent they must be present in order for an occupation to qualify as a profession. As illustration, and of interest to this research, Banks citing Carr-Saunders (1955) names four types of professions:

... the established professions (such as law, medicine, the clergy): the new professions (such as engineering, chemistry, and the natural and social sciences): the semi-professions (such as nursing, pharmacy and social work): and ‘would be’ professions (such as hospital managers). (Banks, 2004, p. 20)

The strategic, the second approach to professions, focusses on the boundaries, exclusivity, education and rituals of membership of professions, all of which can be utilised for economic gain and social and professional status. Finally, the historical/developmental approach considers how professions develop differently according to their time, place (country) and the role of the state, government and legislation (Banks, 2004, p. 23).

Freidson (2001), seeking to bridge these differences, rather than describing what a profession is, developed a set of interdependent elements characteristic of an ‘ideal-typical’ professionalism against which any occupation can be assessed. These characteristics include:

1. Specialized work in the officially recognised economy that is believed to be grounded in a body of theoretically based, discretionary knowledge and skill and that is accordingly given special status in the labor force;
2. Exclusive jurisdiction in a particular division of labor created and controlled by occupational negotiation;
3. A sheltered position in both external and internal labor markets that is based on qualifying credentials created by the occupation;
4. A formal training programme lying outside the labor market that produces the qualifying credentials, which is controlled by the occupation and associated with higher education; and
5. An ideology that asserts greater commitment to doing good work than to economic gain and to the quality rather than the economic efficiency of work. (Freidson, 2001, p. 127)

In this research, counselling, nursing, occupational therapy, psychology and social work are examined, and they are referred to as professions. That there is debate regarding *profession* is recognised but, accepting Freidson's characteristics, all five professions are regarded to meet the criteria. The discussion on professions and professionalism is presented in chapter three and further clarified in chapter nine.

Structure of the Thesis

Chapter one has introduced the context of this research. An overview of the research design, and an overview of the contribution that the research has made to the understanding of the practice of interprofessional supervision, have been presented. The researcher has been introduced and positioned within her background and the professional experience which she brings to the research. How these shape both her interest in interprofessional supervision and the assumptions which are brought by her to the research process are identified. The chapter concludes with an explanation and rationale for the manner in which the term profession is employed in the research.

With reference to the literature, chapter two considers the broad parameters and principles of professional supervision practice. A range of terminology, employed to describe the various arrangements of supervision, is identified as is the struggle, reported in the literature, to find an agreed definition. The functions, commonly ascribed to supervision, are discussed including the different emphasis given to these functions by different professions. The effect of geographical location on supervision practice and structure is also noted. Interprofessional supervision is introduced and the terminology employed to describe this practice presented.

Chapter three sharpens the focus on interprofessionalism. Again, with reference to the literature, the development of interprofessional working is considered along with professional identity, professional status, professionalism and interprofessional education (IPE). The chapter concludes with an examination of the extant research on interprofessional supervision and a summary of the findings of that research.

The rationale for the choice of epistemology and research methodology is considered in chapter four. The four phase sequential research design is presented and the decision making processes for the choice of participant selection (sampling), and methods of data collection and data analysis are described. The chapter concludes with consideration of the ethical issues, constraints and the limitations of the research.

Chapters five, six, seven and eight present the findings of each of the four phases of the research. In chapter five the broad context for the practice of interprofessional supervision is presented (phase one). A review of the legislation which directs health, psychological and social service practice in Aotearoa New Zealand, and an examination of relevant professional and regulatory body policies, are presented alongside the findings from interviews with representatives of five professional or regulatory bodies.

Chapter six reviews the findings from interviews with expert informants on interprofessional supervision (phase two), while chapter seven presents an analysis of live interprofessional supervision sessions (phase three). Finally chapter eight reports on phase four. Feedback on a framework of interprofessional supervision, developed from the findings of phases two and three is considered. A Map for Interprofessional Supervision, as a product of this study, is presented in this chapter.

Chapter nine draws together the findings from the four phases of the research and the literature. The research in its entirety is summarised and key elements which were developed from the overall research, and which underpin the Map for Interprofessional Supervision, are considered. A Diversity Model which describes a new way of interprofessional working is presented. The chapter concludes with identification of the implications of the research for practice. Opportunities for future study are also presented.

Chapter 2: The Supervision Territory

Supervision is a joint endeavour in which a practitioner with the help of a supervisor, attends to their clients, themselves as part of their client practitioner relationships and the wider systemic context, and by so doing improves the quality of their work, transforms their client relationships, continuously develops themselves, their practice and the wider profession. (Hawkins & Shohet, 2012, p. 60)

A Brief History

The emergence of supervision as a feature of practice within the social services has commonly been sourced to social work in the late nineteenth century and attributed to the relationships which were established between volunteers and experienced workers in the Charity Organisation Societies (Tsui, 1997). Whilst there is scholarly debate about this assertion and whether supervision began as an educative function or an administrative function (Tsui, 1997), Robinson (1949) supports the claim that supervision was a unique contribution of social casework. In the preface to her 1949 text on supervision she provides the following description which presents supervision as a transformational, albeit exacting and challenging, activity:

Supervision, from my point of view, is the most original and characteristic process that the field of social casework has developed. Its use of relationship is rooted in the deepest human sources, its movement follows universal psychological laws. Its effectiveness in the production of personality-change, essential for the achievement of skill in the helping process, is undeniable. With all this, perhaps precisely because of it, supervision is instinctively felt to be a dangerous tool, asking more, it may be, of a supervisor to use it responsibly than he is able or willing to take upon himself. (Robinson, 1949, p. viii)

By the beginning of the 20th century psychoanalysts, through the influence of Freud, also engaged in supervision and by the 1920s supervision was a required component of psychoanalytic training (Carroll, 2007). Later, in the mid-to-late 20th century, psychotherapists and counsellors also integrated supervision into their professional practice. Carroll notes that in the beginning of this period there was a blurring in the distinction between therapy and supervision. Observers, he says, “could be forgiven for wondering what was different from the manner in which they supervised to the way they engaged in counselling” (Carroll, 2007, p. 34). By the 1970s counselling/therapy and supervision were clearly delineated. “Supervision now became centered on practice, the actual work done with a view to using that work to improve future work” (Carroll, 2007, p. 34).

By contrast the introduction of supervision into health care professions took a different pathway. Here supervision has traditionally been regarded as a process in the training of students and as a means to oversee new practitioners (Davys & Beddoe, 2010). Consequently for many health professions supervision has been approached with caution and has not, in the first instance, been considered appropriate or necessary for those who are qualified and experienced practitioners.

Within the allied health professions confusion between clinical supervision, professional supervision, performance review and line management continues (Leggat et al., 2016). This confusion may be a legacy from the early association of supervision as a form of training and assessment, or possibly may be due to the “growing managerialism in the public health sector” where supervision has been “afforded a strong role in ensuring the performance of health professionals” (Leggat et al., 2016, p. 434). The understanding of these activities in relation to supervision is differently understood by different professions.

Occupational therapy, “a comparatively early adopter of clinical supervision” (Ayes, Watkeys, & Carthy, 2014), provides, through The College of Occupational Therapists (COT), that supervision is “a professional activity, applicable to all grades, contributing to both job satisfaction and the provision of a high quality service” (COT, 1990, cited in Hunter & Blair, 1999, p. 345). A later amendment specifically addresses the relationship of supervision to other professional activities. “Supervision is not the equivalent of performance review, of counselling or of monitoring; it is a relationship concerning accountability and responsibility for work carried out” (COT, 1997, cited in Hunter & Blair, 1999, p. 345).

Meanwhile Redpath, Gill, Finlay, Brennan, and Hakkennes (2015), discussing supervision for physiotherapists, contend that:

Performance appraisal is inherent to effective supervision, without which an individual's learning and development needs cannot be thoroughly assessed and addressed. The term ‘professional supervision’ might better reflect the purpose and content breadth of supervision that the current participants preferred and is less confusing or misleading for physiotherapists than ‘clinical supervision. (p. 214)

For the nursing profession attempts to introduce supervision have been traditionally regarded with suspicion (Northcott, 2000) and supervision seen as a vehicle for management and for assessment of competence and service delivery (Butterworth, 2001). Nevertheless, supervision in nursing, and for nurses, has been the subject of considerable research and has been championed by scholars and practitioners. Bond and Holland (2010) though, observing

that “the momentum towards clinical supervision has been growing in recent years” (p. 51), also record with concern the length of time that this has taken and the ongoing resistance from the nursing profession to major change in this area of practice.

Two exceptions to the slow implementation of supervision in nursing are noted by Fish and Twinn (1997). In the United Kingdom mental health nursing has engaged in supervision since the 1940s, while a statute laid down in 1902 requires “practicing midwives to receive regular supervision” (Fish & Twinn, 1997, p. 23). This latter supervision, Fish and Twinn however note, is “predominantly grounded in a competency-based model of supervision” (p. 23).

The Struggle for Definition

Although, as Grauel (2002) records, “within the helping professions, widespread agreement exists that supervision is differently nuanced from traditional notions of ‘oversight’” (p. 5), it has long been regretted (Milne, 2007; Milne, Aylott, Fitzpatrick, & Ellis, 2008) that there is no agreed definition of supervision. Rich (1993) notes the absence of a “single definition or theory...by which to describe [supervision’s] meaning, methods, or purpose” (p. 137), while Grauel (2002) refers to supervision as “a malleable concept in search of precise definition” (p. 5). The varied forms of supervision which have been described have created confusion which, Feasey (2002) believes, “centres mainly upon the issue of power and authority, judgement and assessment” (p. 1).

Different professions hold different understandings about supervision (Kelly & Green, 2019) and the supervision literature, Sewell (2018) warns, should be approached with caution. “The nomenclature is used differently, which can impact the relevance of findings and implications for supervision in practice” (Supervision terminology, para. 1). Definitions of supervision reflect beliefs regarding the function and purpose of supervision, are shaped by social, ideological and political agendas, and vary according to profession, within professions and across geographic borders. On a continuum the definitions range from supervision considered as an evaluative activity linked to organisational purpose (Bogo & McKnight, 2006; Mor Barak, Travis, Dnika, Pyun, & Xie, 2009) to supervision as a reflective space leading to transformative learning and aimed to develop and enrich practice (Carroll, 2010; Davys & Beddoe, 2010; Scaife, 2010; Weld, 2012). In some professions supervision, as noted earlier, is required only for students and novices to ensure the development of safe and competent practice, while other professions view it as a central component of critical reflection and career or lifelong learning (Davys & Beddoe, 2010).

Differences of definition persist across national boundaries. Bernard and Goodyear (2009) provide the following definition which is described as widely accepted by mental health professionals in both the United States and Britain (Bernard & Goodyear, 2009; Milne, 2007).

Clinical supervision is an intervention provided by a more senior member of a profession to a more junior member or members of that same-profession. This relationship

- is evaluative and hierarchical,
- extends over time, and
- has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients she, he, or they see; and serving as a gatekeeper for those who are to enter the particular profession (Bernard & Goodyear, 2009, p. 7).

Subjecting this definition to focused critique, and in search of “an empirically derived definition of supervision” Milne (2007) reports that it “failed all four necessary tests of a good definition: precision, specification, operationalization and corroboration” (p. 437). While Ellis (2010), although claiming Bernard and Goodyear’s as his preferred definition, disagrees with the definition on two points. First he does not believe that supervision “necessarily [has] to be between junior and senior people” and second “that supervisors have to be from the same profession” (Ellis, 2010, p. 97).

A key omission in Bernard and Goodyear’s definition is mention of supervision for the experienced practitioner. For these “more senior professionals” Bernard and Goodyear (2009) comment that “supervision often evolves into consultation” (p. 10). This consultation they suggest might involve occasional, informal meetings with a colleague “to get ideas about how to handle a particularly difficult client or to regain needed objectivity.” They conclude by noting that “we all encounter blind spots in ourselves, and it is to our benefit to obtain help in this manner” (Bernard & Goodyear, 2009, p. 10). Others disagree. The process of clinical supervision, according to Bond and Holland (2010), “should continue throughout the person’s career, whether they remain in clinical practice or move into management, research or education” (p. 15). More cautiously Watkins (2014), referring to supervision in the United States of America, suggests that “career-long supervision will continue to slowly rise on the agendas of a growing number of professional associations and eventually become more established practice (p. 256).

As will be detailed in chapter five, this does not reflect the practice of supervision within Aotearoa New Zealand's health, psychological and social service professions. Though there are exceptions, for example nursing and physiotherapy, in Aotearoa New Zealand supervision is generally mandated by each profession's regulatory authority or professional body where ongoing, career-long, professional supervision is required for all post-qualified practitioners.

Although traditionally an activity which occurs through a one-to-one process between a designated supervisor and an individual (supervisee), it is useful to note that supervision may also occur in other forms. The most common variations include group supervision, team supervision and peer supervision. The latter may take place between two peers or colleagues or may be through a group forum and again national boundaries highlight differences between professions. Watkins and Milne (2014), discussing the responsibilities of supervision in the United States of America contrast this to practice development in the United Kingdom. With reference to supervision between peers, which they note is supported by the British National Health Service, they comment that "peer supervision is an informal, leaderless arrangement where no one has authority, making the term an oxymoron, a dangerous nonsense because it negates these responsibilities and flattens the necessarily hierarchical relationship" (Watkins & Milne, 2014, p. 685). They do not consider this practice to be supervision and suggest that such arrangements between peers should instead be termed "peer consultation".

Terminology employed in conjunction with supervision is thus also varied and includes: clinical supervision (Bond & Holland, 2010), professional supervision (Davys & Beddoe, 2010), reflective supervision (Beddoe, 2011), administrative clinical supervision (Sirola-Karvinen & Hyrkäs, 2006) cultural supervision (Crocket et al., 2013), Kaupapa Māori supervision (Eruera, 2012), external supervision (Busse, 2009), internal supervision (O'Donoghue, 2006), interprofessional supervision (Townend, 2005), and the list goes on. The range of supervision terms identified here is by no means exhaustive and, in keeping with the definitional debates described earlier, there is no necessary agreement as to what each activity involves. What is relevant and important for this research is to remember this variation and diversity at all times, and to carry an appreciation that no assumptions can ever be made regarding the meaning of any supervision activity, definition or process.

Finally, appended to this discussion of the parameters of supervision, is the debate which surrounds the very name supervision. The term supervision for a number of professions is prerogative. Speaking of teachers and the medical profession Shohet (2011) observes, "for

those professions supervision can seem like a remedial word, or the idea of being checked up on, and coaching and mentoring are more acceptable terms” (p. 11). For Shohet (2011) the distinction between these three terms is not important as he sees them to be closely aligned. For the purposes of this study I take a similar position to that of Shohet who considers that all these activities embody “the idea of making protected time and space to reflect so we can become proactive rather than reactive to the multiple demands that are made on us” (p. 10).

In an associated critique, ‘supervision’ when considered as a verb confers authority and power to the activity of supervision. The supervisor supervises, whereas the supervisee is accorded the more passive role as the recipient of that supervision:

Typically, the supervision relationship is depicted in such a way that counselors are produced as people to be acted *upon* in supervision: to be developed, to be subject to assessment and appropriate intervention, to have their practice monitored and evaluated. Counselors are thus found in subjected positions in most accounts of supervision. (Crocket, 2004, p. 173)

Crocket (2004) continues and describes an approach to supervision which promotes the “professional author–ity (sic)” (p. 173) of the supervisee. In many respects this argument becomes circular and returns to the earlier discussion which described the manner in which beliefs about the function and purpose affect definitions and practice of supervision. While acknowledging this debate about the naming of the people who engage in supervision, in this research the traditional terms of supervisor and supervisee are employed. This is a pragmatic approach which seeks to simplify the language and avoid lengthy disclaimers about meaning. The terms here are used as basic descriptors of the two people who join in a supervision relationship.

The Function(s) of Supervision

Within the nuances of definition and the variations of perspective, most professions which incorporate supervision as a component of professional practice agree that the functions of supervision are three-fold. A number of functional models of supervision can be identified. Typically these models include a function which specifies accountability to organisational and professional standards, ethics and competencies, a function which addresses professional development and learning and a function which recognises the need for practitioner support and replenishment. For example: the administrative, educative, supportive (Kadushin, 1976); the normative, formative and restorative (Inskipp & Proctor, 1993); qualitative, developmental, resourcing (Hawkins & Smith, 2006).

Where the professions differ, again as discussed earlier, is in the emphasis on, or priority given, to different functions. As Wonnacott, (2012) observes the “degree to which the supervisor has management accountability for the work which is being undertaken” (p. 22) is one of key differences between professions. In a similar vein Bond and Holland (2010) suggest that this difference reflects the manner in which different professional cultures explicitly value “management monitoring” on the one hand and “therapeutic use of self” on the other hand (p. 36). Midwifery where, they suggest “managerial monitoring” is the aim of supervision, sits at one end of their continuum. Psychotherapy, where the aims are “support, development and professional monitoring”, sits at the other.

The location of supervision as an agency-specific process, commonly linked to line management roles, has long been a feature of social work supervision (Bogo & McKnight, 2006; Hair, 2014). O’Donoghue and Tsui (2012) argue that the rise of managerialism at the end of the 1980s significantly increased the influence of organisations on social work supervision practice. An influence considered by O’Donoghue and Tsui (2012) to be to the detriment, rather than the benefit, of social work practitioners. They note that rather than identifying with their profession, social workers began to identify with their employing bodies and there was “a marked shift in emphasis from educational and professional development to conformance with organizational performance management and accountability systems” (O’Donoghue & Tsui, 2012, p. 10).

In subsequent decades since the 1980s, recognition of the complexity and rate of change within service delivery has brought some challenge to this dominant focus on organisational accountability in social work. An early call in the social work supervision literature called for a separation of the managerial function from the educative and supportive functions (Payne, 1994) and recognised the need for “in-depth, critical, personally focussed supervision” (Beddoe & Davys, 1994, p. 20). The gap between the rhetoric and practice however is evidenced in continuing reports by social workers of supervision agendas which deal primarily with targets and outcomes (Egan, Maidment, & Connolly, 2015; Manthorpe, Moriarty, Hussein, Stevens, & Sharpe, 2013).

In Britain, Lord Laming (2009) in his report on “The protection of children in England” wrote:

There is concern that the tradition of deliberate, reflective social work practice is being put in danger because of an overemphasis on process and targets... Supervision should be open and supportive, focusing on the quality of decisions, good risk analysis, and improving outcomes for children rather than meeting targets. (p. 32)

Morrison and Wonnacott (2010), again in the British context, urge for practice audit to be removed from social work supervision and for supervision to primarily concern exploration and critical analysis of practice. Meanwhile, the Australian Association of Social Workers adopted a definition of professional supervision in social work which explicitly names supervision as “a forum for reflection and learning” (AASW, 2014).

In a critique of cultural responsiveness, Hair and O’Donoghue (2009) speaking of supervision practice in Canada and Aotearoa New Zealand, challenge the traditional ‘empiricist’ assumptions of social work supervision which “reifies the supervisor as expert, potentially discounts the knowledge of the social worker, and ignores the complex cultural and political contexts of social workers and the people they serve” (p. 84). In a later publication Hair (2014) concludes that “when supervisors are willing to deconstruct notions about expert knowledge, then they are able to invite collaborative, co-creative conversations with social workers” (p. 111). Such conversations she notes will enable critical reflection within a framework which is also alert to ethical, risk and organisational issues (p. 107).

In the United States of America traditional definitions of social work supervision persist. Kadushin and Harkness (2002) describe the social work supervisor as “an agency administrative-staff member to whom authority is delegated to direct, coordinate, enhance, and evaluate the on-the-job performance of the supervisees for whose work he or she is held accountable” (p. 23). In a similar vein, drawing on the work of Munson and his definition of social work supervision, Bogo and McKnight (2006) describe the parameters of social work supervision as “agency-based, hierarchical, and [including] an evaluative component” (p. 52). The supervision of social work practitioners is thus seen to be primarily an administrative function, “put more crassly, workers are hired by an agency to do a job and supervisors oversee that the job is done well” (Bogo & McKnight, 2006, p. 50).

Social work supervision is regarded by these scholars as a form of supervision practice to be distinguished from clinical supervision. The latter, Bogo and McKnight (2006) assert, concerns “the dynamics of the client situation and the social worker’s interventions” (p. 52), and only involves the educational and supportive functions of supervision. Citing the American Board of Examiners in Clinical Social Work (2004) which draws a distinction between an agency employed supervisor who has conferred authority and accountability and a consultant who provides education and expert opinions, Bogo and McKnight (2006) urge for “consistent use” of these terms to avoid confusion (p. 52). Nowhere in their discussion of the definition of social work supervision do Bogo and McKnight (2006) mention learning (as opposed to education), exploration or reflective practice as being components of supervision.

Similarly, accountability is presented as a process which is defined and authorised by the employing body with an emphasis on audit rather than best or ethical practice.

In other professions the relationship between supervision and management is clearly prescribed and/or proscribed. For nursing the separation of supervision from management is critical. "...the level of disclosure required to do in-depth reflection is not appropriate to a manager-subordinate relationship" (Bond & Holland, 2010, p. 97). At the same time Carroll (2014), from a background in counselling psychology, warns that "where managerial and clinical supervision merge supervision can be seen as a form of control, creating docile and conforming practitioners" (p. 11). When supervision is thus separated from management a vigorous body of scholarship promotes the relationship between critical reflection in supervision and responsive practice (Bond & Holland, 2010; Carroll, 2010; 2014; Hawkins & Shohet, 2012; Scaife, 2010). A contrary opinion is voiced by Westergaard (2013) who suggests that the principles and practice of supervision override the constraints and tensions of the duality of the manager/supervisor roles:

Supervision is a supportive relationship that ensures the development of best professional practice in client work. Regardless of the position of the supervisor, be they external to the organization or the supervisee's line manager, adherence to these functions is paramount. Supervision is an activity viewed as fundamental to ensuring the development and maintenance of professional, reflective, and ethical practice. (p. 168)

Nevertheless the influence of power is well noted in the supervision literature, as is the added complexity when difference, with all of the variations which include culture, gender, age and profession, is considered (Brown & Bourne, 1996; Copeland, Dean & Wladkowski, 2011; Hawkins & Shohet, 2012; Hair, 2014; Noble, Grey, & Johnston, 2016). Hawkins and Shohet's (2012) triangle of power dynamics identifies three types of power in supervision: role power, cultural power and personal power (p.121). Role power describes the power which accompanies the role, or position, of supervisor. This power is defined and prescribed by professional and/or regulatory bodies and will include the power vested in the supervision role by organisational policy and mandate. The supervisor's role authority and power are reinforced when they also hold a line management position. Cultural power recognises the broader context, the social, professional and ethnic groups to which the supervision participants belong and the dominance and status of these groups. As will be discussed in chapters three and six, in interprofessional supervision, there is an interface between professions where status and expertise must be recognised and addressed. Finally personal

power refers to the power which accompanies personal status, expertise and knowledge, cultural position and personal charisma.

Copeland et al., (2011) noting that traditional models of supervision conferred considerable expertise and power to the supervisor, argue that post-modernist approaches to supervision have challenged this dominance in recent decades. There is now “an emphasis on meaning that is co-constructed through dialogue, and a view of the supervisory relationship as collaborative rather than hierarchical” (p. 28). Although the preceding discussion demonstrates that this argument does not hold true for all professions, in all locations, Copeland et al.’s views are supported by research. Hair (2014) for example, concludes from a survey of 636 social workers, that “the power relations of supervision can be transformed from a dualistic relationship of the dominator and the dominated into a complex, dynamic interrelationship where expert knowledge can be deconstructed and alternative knowledge can emerge” (p.111).

Within this varied emphasis on the importance of particular functions, as viewed by different professions, and from a consideration of the influence of power within supervision, a question is raised – where does the authority reside within supervision arrangements? Crocket, Cahill, et al., (2009) wonder if “where there is no professional or organisational mandate, whether the practice is always appropriately called ‘supervision’. Is any privately contracted reflection on practice ‘supervision’?” (p. 39).

The answer would appear to lie in the underlying values and practice brought to supervision by the participants. For those who subscribe to a hierarchical model the authority rests with, or is conferred on, the person who holds the ‘position’ of supervisor. For others who regard supervision as a collaborative process within which individuals negotiate and enact the different roles, the authority is shared and mutual. In this latter scenario it is necessary to consider that the participants each hold responsibility and professional accountability which is independent of their particular supervision arrangement. They bring to the supervision relationship their particular areas of accountability and so remain individually “accountable to professional standards and defined competencies and to organisational policy and procedures” (Davys & Beddoe, 2010, p. 21). This is particularly relevant when supervision takes place across professions. The supervisor from one profession is accountable to the standards, ethics and policies of his or her profession. The supervisee, from another profession (and possibly organisation), has a different set of accountabilities to which he or she is equally accountable.

Interprofessional supervision considers the practitioner as a professional who, aware of his or her professional (and organisational if the supervision is external to the organisation) responsibilities and accountability, brings these into the supervision relationship. Whilst the supervisor holds the responsibility to ensure that these areas are covered, the manner by which this occurs is through joint negotiation. (Beddoe & Davys, 2016, pp. 150–151)

Alongside these descriptions of supervision, and adding to the complexity of achieving any agreed understanding or definition, is the range of terms used to describe different aspects or types of supervision. Carroll, (2014) describes six types of supervision. The first three types, normative supervision, formative supervision and restorative supervision represent the functions of supervision mentioned above. The fourth, systemic supervision, places “practice in ever widening contexts which give it deeper meaning”, the fifth, transformative supervision ensures “that the learning involved is not just theoretical or espoused learning, but learning that is translatable into action and changed practice”. Finally administrative supervision sets up, organises and maintains “the process of supervision through effective administration and organisation” (Carroll, 2014, p. 7). For Carroll (2014), any or all of these types of supervision may occur at different times within the same supervision relationship, “they complement each other rather than compete” (p. 7).

For other researchers, scholars and or practitioners, one or other of the types of supervision may form the basis of separate arrangements between the practitioner and different supervisors, mentors, managers or clinical leaders. The most common separation being that of the administrative or management supervision from the reflective learning types of supervision. This separation of supervision arrangements has been variously named a “mosaic of strategies” (Garrett & Barretta Herman, 1995, p. 97), “mosaic of supervision” (Beddoe & Davys, 2016, p. 223) and “supervision portfolio” (O’Donoghue, 2015, p. 146).

Effectiveness of Supervision

Assertions regarding the usefulness and effectiveness of supervision have long been present in the supervision literature, for example:

High quality supervision is one of the most important drivers in ensuring positive outcomes for people who use social care and children’s services. It also has a crucial role to play in the development, retention and motivation of the workforce. (Skills for Care and the Children’s Workforce Development Council, 2007, p. 2)

Evidence to attest to this effectiveness however has been light (Bernard & Goodyear, 2009; Carpenter, Webb, & Bostock, 2013; O’Donoghue & Tsui, 2013; Watkins, 2011; Wheeler &

Barkham, 2014). Debate has also centred on what criteria should be used for any such measurement. Typically, two questions have been asked in the studies which have been conducted:

Does supervision have a beneficial effect on supervisees (the positive impact of supervisor on supervisee)?, or Does supervision actually have a beneficial effect on supervisees' patients (the positive impact of supervisor on supervisee, which in turn positively impacts patients)? (Watkins, 2011, p. 236)

In response to the first question Carpenter et al. (2013), considering the supervision of child welfare workers, reviewed the research literature over a period of twelve years from 2000 – 2012. From this they found “evidence of associations between the provision of supervision and a variety of outcomes for workers, including job satisfaction, self-efficacy and stress and for organizations, including workload management, case analysis and retention” (Carpenter et al., 2013, p. 1843). In a similar, but longer (30 years), systematic review of the research on psychotherapy supervision Watkins (2011) found that supervisees benefited from supervision through “enhanced self-awareness, enhanced treatment knowledge, skill acquisition and utilisation, enhanced self-efficacy, and strengthening of the supervisee-patient relationship” (p. 236).

Whether supervision has “a beneficial effect on supervisees' patients”, Watkin's (2011) second question, is less clear. A lack of reliable measures by which to evaluate this effectiveness is commonly noted within the literature (Bernard & Goodyear, 2009; Carpenter et al., 2013; Milne, 2014; Watkins, 2011) and scholars differ in their assessment of the progress to date. Existing studies concerning the effect of supervision on clients have been critiqued as lacking in methodological rigour (Watkins, 2011), while Wheeler and Barkham (2014) report “a lack of logical progression between the studies and minimal evidence that researchers were trying to build on the evidence of previous research” (p. 367). It is also noted that much of this research concerns students or trainees, with a corresponding neglect of the supervision experiences of experienced practitioner (Crocket, Pentecost, et al., 2009; Wheeler & Barkham, 2014). More recent comment from Watkins (2014) suggests some progress and, referring to recently developed measures, he concludes that these are “examples of supervision validation research at its best and serve as prototypical exemplars of how the development of more valid, reliable supervision-specific measures can be moved from the drawing board to practical reality” (p. 260). Others remain unconvinced and continue to report little progress in the development of measures by which to evaluate

supervision's effect on practitioners or those with whom they work (Falender & Shafranske, 2014a; Tsong & Goodyear, 2014).

Not everyone supports the need, or the ability, to evaluate supervision in this manner and the question has been raised as to whether such evaluation constrains and reduces the very activity of supervision:

By trying to impose on the activity of supervision manualised interventions and the 'gold standard' randomised trial, we fail to study the activity in question, but rather are in danger of changing the activity to something else in order to make it more researchable. (Scaife, 2001, p. 84)

Interprofessional Supervision

Interdisciplinary supervision can be defined as two or more [practitioners] meeting from different professional groups to achieve a common goal of protecting the welfare of the client. This protection is achieved through a process that enables increased knowledge, increased skill, appropriate attitude and values ... to maintain clinical and professional competence. (Townend, 2005, p. 586)

Given the preceding discussion, it is evident that any supervision arrangement which straddles professions must recognise and accommodate differences in definition, difference of understanding of responsibility and differences of task. Carroll (2014), reflecting on his involvement in supervision with practitioners of different "professional orientations and cultures", comments that this has forced him to review what he means by supervision and how supervision differs, "and should differ", when applied to each new context (p. 4).

A range of terms has been employed to describe the supervision which takes place between practitioners from different professions and includes labels such as "cross disciplinary" (Crocket, Cahill et al., 2009; Hair, 2013; Hutchings et al., 2014; O'Donoghue, 2004), "multi disciplinary" (Gillig & Barr, 1999), "multi professional" (Mullarkey, Keeley, & Playle, 2001) and "interprofessional" (Beddoe & Howard, 2012; Bogo et al., 2011; Townend, 2005). This range of terminology is confusing and, as McCallin (2001) argues with regard to professional practice, the random use of prefixes "such as inter, multi, and trans" has the consequence "that the descriptions in the professional literature are so diverse that meaning is murky" (p. 421).

The literature can be similarly unclear in the use of 'discipline' and 'profession'. "A discipline exists from the moment a set of 'knowledge' comes to be policed by a system of rules, which are applied in the purpose of transforming this knowledge into a body of

knowledge” (Couturier, Gagnon, Carrier, & Etheridge, 2008, p. 342). D’amour and Oandasan (2005) describe interdisciplinarity as “a response to the fragmented knowledge of numerous disciplines. Each discipline is based on a sum of organized knowledge” (p. 9). Interdisciplinarity, they say, “wishes to reconcile and foster cohesion to this fragmented knowledge” (D’amour & Oandasan, 2005, p. 9). Couturier et al. (2008) in turn argue that ‘inter’ “is concerned with the meeting of disciplines on three distinct levels of endeavour, namely the professional, academic and research levels. Accepting that each of these levels will have its unique ‘discipline-specific’ issues and conditions they conclude that “‘interprofessionality’... has the same fundamentals as interdisciplinarity” (Couturier et al., 2008, p. 342).

D’amour and Oandasan (2005) disagree. Interprofessionality, they assert is “the development of a cohesive practice between professionals from different disciplines” (p. 9). Interprofessional supervision is well positioned to fit this definition. Supervision which occurs between practitioners from different professions requires the employment of a cohesive set of principles, skills and knowledge about the practice of supervision which is variously informed, but not defined, by individual disciplines. Clark (2006) likens profession or discipline knowledge to toolkits which the participants bring to the interprofessional encounter as a resource, rather than a blueprint for practice. As Beddoe and Howard (2012) observe, supervision “if practiced according to this framework, would extend beyond that typical of professional supervision, to encompass a philosophy of practice whereby the professionals involved all ascribe to interprofessional ways of working” (p. 183).

Acknowledging this debate regarding the naming of practice between different professions and disciplines, and in line with previous scholarship, (Beddoe & Davys, 2016; Beddoe & Howard, 2012; Bogo et al., 2011; Davys & Beddoe, 2008; 2015; Townend, 2005), in this research the term ‘interprofessional’ has been chosen, to describe this form of supervision between practitioners of different professions.

Interprofessional supervision, at its most basic, can be described as professional supervision which occurs between a supervisor and a supervisee who do not share the same professional or discipline background. Townend (2005) expands this definition. The participants of interprofessional supervision, he says, share the “common goal of protecting the welfare of the client”. The means by which this goal is achieved is through “a *process* [emphasis added] that enables increased knowledge, increased skill, appropriate attitude and values to maintain clinical and professional competence” (Townend, 2005, p. 586).

A break from tradition.

Professional supervision, which traditionally takes place between practitioners who belong to the same profession, is commonly shaped by the assumptions, and presumptions, of a common knowledge of theory, skill, practice standards and ethics. Such supervision has been termed “supervision as a field of practice within a profession” (O’Donoghue, 2004, p. 4). Interprofessional supervision therefore introduces a significant challenge to this mode of supervision practice. It represents a shift away from traditional forms of supervision and indeed traditional ways of working. This shift over time has been captured in the supervision literature. In the first edition of their seminal book on supervision, Hawkins and Shohet (1989) comment that they are, on occasion, asked whether the supervisor should have the same training as the supervisee. In these situations they recommend that both parties “share enough of a common language and belief system to be able to learn and work together” (Hawkins & Shohet, 1989, p. 48). By the fourth edition of that same book (Hawkins & Shohet, 2012), interprofessional supervision, though not addressed as a separate topic, is presented as a norm of practice. “Often the supervisor and supervisee may belong to the same profession but in many cases the supervision may take place across professions or orientations with different codes” (Hawkins & Shohet, 2012, p. 70).

Traditional supervision partnerships, where professional knowledge and practice are held in common between the supervisor and the supervisee, are often seen to place greater value on the supervisor’s knowledge and competence within that profession than on his or her competence as a supervisor. A common assumption across many professions is that a competent practitioner will automatically be a competent supervisor (Bernard & Goodyear, 2009; Davys & Beddoe, 2010). Many supervisors report a closed loop where their primary ‘training’ for being a supervisor comes from their experience of ‘being supervised’ (Milne, 2009; Spence, Wilson, Kavanagh, Strong, & Worrall, 2001). Thus practitioners continue to find themselves promoted to the role of supervisor on the basis of their years of practice, experience and expertise as opposed to their ability to supervise others (Hair, 2013; Maidment & Beddoe, 2012; Strong et al., 2004).

Supervision research, in all fields of professional practice, has long identified a lack of adequate preparation and a lack of training for the role of supervisor (Davys & Beddoe, 2010; Egan, 2012; Hair, 2013; Milne, Sheikhh, Pattison, & Wilkinson, 2011; Strong et al., 2004). Whilst Watkins (2014), who reports that the importance of education for supervisors has been largely accepted in the last decade, notes that the availability of appropriate training and organisational support is not always assured.

Interprofessional supervision, whilst still valuing professional competence, equally requires supervisors to demonstrate expertise as a supervisor. Returning to Townend's (2005) definition, the process of interprofessional supervision "enables increased knowledge, increased skill, appropriate attitude and values to maintain clinical and professional competence" (p. 586). The key features of interprofessional supervision, by this definition, are the processes through which the goals of supervision are achieved, rather than the specific professional knowledge held by the supervisor.

Decisions by practitioners about the best, or most appropriate, form of supervision with which to engage can be influenced by several factors:

1. The definitions, expectations and requirements of supervision as specified by professional and/or regulatory bodies. Including such things as frequency, reporting, accountability and the supervisor's competence (qualification and professional knowledge).
2. The expectations and requirements of employing organisations which may include: frequency, reporting, accountability, cost and time. Supervisor competence, qualification, professional knowledge/expertise and availability may also be considerations.
3. The legislation which mandates the professional practice. Supervision may be employed to assure and monitor standards and/or competence.
4. Individual practitioner criteria: including individual practice and learning needs, personal/professional definition of supervision, professional compliance, organisational support, choice of supervision relationship, resourcing.

Those professions and practitioners who understand supervision to be a forum for organisational audit of cases, of risk and of practitioner competence are unlikely to consider interprofessional supervision to be an acceptable mode of supervision practice. Supervisors and practitioners who consider supervision to be about giving advice and expert instruction may similarly be uncomfortable in a supervision process where 'unknowing' is regarded as a process for critical reflection and learning.

"Supervision is a strategic withdrawal to meditate, contemplate, and think about our work" (Carroll, 2010, p. 13). Those practitioners who consider supervision to be a forum for development and learning, for critical reflection and transformative practice, will value relational skills, broad practice wisdom and open enquiry. "Creating the conditions for critical reflection is not easy. It demands openness and 'indifference' to where the outcome

will lead. For those already committed to an existing outcome or destination, critical reflection can become impossible” (Carroll, 2010, p. 8). Practitioners who appreciate and value these features of supervision may consider a range of ‘modes’ of supervision, one of which is interprofessional supervision.

This chapter considers the parameters and historical development and practice of supervision from the perspectives of different professions in different locations. Interprofessional supervision is introduced and considered as a new and different way of working. The next chapter develops the discussion of interprofessionality. Through a review of the literature the rationale for and challenges of, this way of working are considered with particular attention to professional identity. The contribution of IPE is noted and the chapter concludes with a comprehensive review of the findings of research which has specifically targeted interprofessional supervision.

Chapter 3: The Interprofessional Territory

Interprofessional supervision occupies a unique space which is informed on the one hand by supervision theory and practice, and on the other hand is influenced by the developing practice of interprofessionality. Chapter two introduced the parameters and principles of supervision and chapter three will review the interprofessional context. Literature and research will be discussed which considers: interprofessionality, professional identity, professional status and professionalism, and IPE alongside the extant research on interprofessional supervision.

Interprofessionality

Interprofessionality (Hudson, 2002; D'amour & Oandasan, 2005), also referred to as interprofessional working (Banks, 2004; Masterson, 2002), interprofessional practice (IPP) (McNeil, Mitchell, & Parker, 2013) collaborative practice (Green, 2013) and interprofessional collaborative practice (IPCP) (Ogletree, 2017), though a feature of professional working in health for some decades (Banks, 2004; Brandt, Lutfiyya, King, & Chioreso, 2014) began slowly. Seven years after Leathard's (1994) urgings "that inter-professional work issues must be documented because the concept is new" (cited in McCallin, 2001, p. 420), McCallin (2001) noted that the professional literature on interprofessional practice remained sparse. Hudson (2002) meanwhile recorded "widespread scepticism on the part of academics" (p. 9) regarding the success of interprofessional working. Notwithstanding these early beginnings, increased enthusiasm, research and theorising in this area have been reported during the last twenty years (Fox & Reeves, 2015; Green, 2013).

In the early literature a useful distinction is made between multi-professional working and interprofessional working. This differentiation both paves the way for the development of an understanding of interprofessional work and anticipates some of the tensions which arise. Multi-professional work is described by Carrier and Kendall (1995) "as a co-operative enterprise in which traditional forms and divisions of professional knowledge and authority are retained. More radically" they continue "interprofessional work implies a willingness to share and indeed to give up exclusive claims to specialized knowledge and authority if the needs of clients can be met more efficiently by other professional groups" (Carrier & Kendall, 1995, p. 10).

Subsequently a range of definitions of interprofessional working have been offered and these can be considered as positioned along a continuum of increasing cohesion and integration of practice. To Hudson's definition of interprofessionality as "effective joint working between separate but related professionals" (Hudson, 2002, p. 7), D'amour and Oandasan (2005), as previously noted in chapter two, introduce the idea that interprofessionality is the creation of something new, "the development of a cohesive practice between professionals from different disciplines" (p. 9). This definition is expanded by Bridges, Davidson, Odegard, Maki, and Tomkowiak, (2011) to "a communication and decision making process performed by a diverse group of professionals, producing a synergy of grouped knowledge and skill" (p. 2). Finally Sylvester, Ogletree, and Lunnen (2017) refer to IPCP (interprofessional collaborative practice) as "the ongoing implementation of interprofessionalism". This they say "appears as a reflective, integrative, and cohesive process in which professionals are engaged, with each other, and with patients and their stakeholders, in continuous interaction and knowledge-sharing to address a variety of care and advocacy issues" (p. 205).

Other definitions, as signalled by Carrier and Kendall (1995, p. 10), note the tension inherent in interprofessional working which requires "a willingness to share and indeed to *give up* [emphasis added] exclusive claims..." In acknowledgment of this Hudson (2002, p. 9) includes professional discretion and accountability as factors which can negatively affect interprofessional working. The differential capacity of professional groups to make decisions and act independently of the organisation, he states, needs to be understood and respected in interprofessional fora. This, Hudson continues, may mean a relinquishing of power and autonomy by some and require a shift from decision-making based on expertise to decision-making which considers a greater holistic picture. This possibility of being required to cede autonomy and control and to consider alternative ways of working, poses a sizable threat for many. Interprofessionality, it has been reported, fosters competition and the ensuing power struggles between professions can threaten professional integrity and professional identity (Banks, 2004; Fox & Reeves, 2015; Khalili, Hall, & DeLuca, 2014; McLean & Fisk, 2015). In a similar vein, Banks (2004) contends that true interprofessional working "may entail some interchangeability of professional roles" which, she adds "appears to threaten the idea of distinct professional groups each with their sets of guiding ideas and ethical principles" (p. 8).

Fox and Reeves (2015) provide a broader perspective and note that discourses on interprofessional collaboration "are often accompanied by pronounced attempts to put the

patient ‘at the centre’ of the care team” (p. 113). They argue that much of the discussion which surrounds interprofessional collaboration largely:

ignore[s] the inequitable social, political, and economic conditions in which health care providers work, and efforts to put patients at the “centre of the team” assume that patients want and are able to take on the responsibilities that come with that role. (Fox & Reeves, 2015, p. 113)

It is alongside this developing conversation about interprofessionality that the present research is considered.

The rationale for interprofessional working.

Characterised in early years by traditional hierarchical interactions between nurses and doctors (McCallin, 2001, p. 421), the current rationale for interprofessionality varies according to perspective. For some it is the logical consequence of increasingly complex health and social service provision where fine understanding of the unique service offered by each different profession and the development of collaboration and cooperation between them, is believed to deliver the best service to service users (Boland, White, & Adams, 2018; Bostock, 2015; Fisher, Weyant, Sterrett, Ambrose, & Apfel, 2017; Khalili et al., 2014; McNeil et al., 2013; Sylvester et al., 2017). Or, as alternatively suggested by Hood (2012), “interprofessional working becomes necessary in order to deal with complex problems that defeat the expertise of professionals working separately or on their own” (p. 6). At the global level, the World Health Organization Framework for Action (World Health Organization, 2010, p. 12) signals urgency for the necessity for this collaboration in the provision of effective health services:

Governments around the world are looking for innovative, system-transforming solutions that will ensure the appropriate supply, mix and distribution of the health workforce. One of the most promising solutions can be found in interprofessional collaboration. (World Health Organization, 2010, p. 12)

For others, a more critical analysis views interprofessionality as a feature of neo-liberalism with associated regulation, target setting, accountability, privatisation of health and social services and organisational management (Cameron, 2011; DeMatteo & Reeves, 2013). Neoliberal political ideology, which gained traction in the 1980s following the failure of the Keynesian economic models (Flew, 2014), is simply described by Ferguson and Woodward (2009): “... neoliberalism has led to services operating on a business rather than a nonprofit model, a reduced role for the state in direct welfare provision, privatized services, increased

service-user choice and user-pay models, and intense competition for government-contracted services” (Ferguson & Woodward (2009) in Gray, Dean, Agllias, Howard & Schubert 2015, p.370).

DeMatteo and Reeves (2013) warn of the need to recognise and understand the “social context underlying the current shift toward interprofessionalism” (p. 32) to avoid interprofessional projects being hijacked to support the privatisation and corporatisation of neo-liberal agendas. At the practice level it is argued that interprofessionalism, when associated with increased levels of regulation, fiscal control and reporting, curtails the independent decision making and autonomy of professions, posing what Banks (2004) describes as a “serious threat to professional ethics” (p. 8). In Green’s (2013) view “the notion of professionalism has transformed from an emphasis on situation-specific professional judgement to a willingness to adapt to policy priorities” (p. 40). The attributes of interprofessionalism are possibly well summed up by Masterson (2002) who, when reflecting on the changes to traditional patterns of service delivery and professional relationships, observed that “these changes have been seen simultaneously as a golden opportunity for true interprofessional working and a threat to professional sovereignty” (p. 333). For those working in these interprofessional settings, navigating these opportunities and threats can be tricky and requires both clarity of purpose and task and a firm understanding of professional goals and accountability.

At a political level “partnership working” states Hudson (2002) “is now a central plank of public policy in the UK, especially in the field of health and social care” (p. 7). Hudson however noted that efforts to promote partnership had a “focus upon inter-organisational working [which] has not been matched by equal attention to interprofessional relationships” (p. 7). Hudson (2002) identified three factors which affect interprofessional working: professional identity, professional status and finally professional discretion and accountability. Asserting that professional identification with a particular body of knowledge not only affects ‘problem solving’ but also ‘problem setting’ he contends that agreement is more likely between members within the profession than between those outside of it.

Professional identity, professional status and professionalism.

Professional identity, which “involves the attitudes, values, knowledge, beliefs and skills that are shared with others within that profession” (Beddoe, 2013, p. 27) is a recurring theme throughout the literature on interprofessionalism. On the basis of a literature review on professionalism, Hudson (2007) developed a list of six key dimensions which may be seen to

inhibit interprofessionalism. These dimensions identified the difference and distinctiveness by which professions established their uniqueness and determined their boundaries. The six dimensions included distinctiveness of: trait, knowledge, status, power, accountability and culture. Drawing these together, Hudson (2007) concluded that these features culminate in the “establishment of a professional identity that becomes a valued part of personal identity, and one that is protected and nurtured by the profession” (p. 5).

“A central paradox dwells at the heart of interprofessional care: the tension between autonomy and interdependence” (Lingard et al., 2014, p. 1). While Lingard et al. (2014) found that this paradox could be a “highly productive tension” (p. 16), McNeil et al. (2013) note that where IPP has not been successful many of the difficulties have stemmed from “interprofessional conflicts based on differences associated with, and threats to, professional identities” (p. 291). They maintain that understanding the development and maintenance of professional identity is important if IPP is to be successful. Professional identity, McNeil et al. (2013) suggest, can be considered at two levels, the macro and the micro. The macro level they see as including elements such as “status, privileges, duties and self-image of the profession” while the micro level refers “to the tacit behavioural norms of the profession” (p. 293). Citing Wackerhausen, (2009) McNeil et al. (2013) also note the influence of the ‘narrative’ which accompanies professional identity and which, among other things, repeats the histories, successes, qualities, status and injustices as perceived by the profession. In the interprofessional encounter McNeil et al. (2013) identify a variety of sources of potential threat to professional identity which stem from: “differential treatment of professional groups, different values between professions, assimilation, insult or humiliating action and simple contact” (p. 291).

It is useful to consider professional identity in terms of its particular relationship to the associated concept of professional status. Professional status in turn is closely connected to professionalisation. Professional status, according to Hudson (2002), is reflected in the official and often unofficial hierarchy of professions which rests on the division of labour and on social differences. The hierarchy itself is established on such issues as length of training, registration, and autonomy of practice. Hudson observes that this difference in professional status may be a primary source of conflict between professionals. Loxley (1997) is less diffident. “Conflict” he says “is interwoven with interprofessional collaboration because there are deep rooted social differences in the division of labour which has developed over the last 200 years in the health and social services” (Loxley, 1997, p. 1).

Traditionally, professionalisation, as a process, has thus been considered to reinforce professional status:

[Professionalisation] serves to secure and protect exclusive areas of knowledge, skills and expertise. In practice, professionalization has contributed toward the development of professions who view one another as rivals – controlling who has access to their particular profession’s “knowledge” through regulated professional entry. (Khalili et al., 2014, p. 93)

Such rivalry echoes Hudson’s (2002) earlier recognition of the challenge posed to professional discretion and accountability by interprofessional working.

Evetts (2011) in turn refers to this professional discretion and accountability as professionalism, distinguishing between occupational professionalism and organisational professionalism. Citing Freidson, 2001, Evetts (2011) presents traditional occupational professionalism as centred on a belief that “education, training and experience are fundamental requirements but once achieved (and sometimes licensed) then the exercise of discretion based on competences is central and deserving of special status” (p. 410). This, she notes, places the professional in a position where judgement is exercised through exclusive knowledge, and external control of the profession is minimal. A more “pessimistic interpretation” of this occupational professionalism she observes, however, sees professionalism as a promotion of the “professional practitioners’ own occupational self-interests in terms of their salary, status and power as well as the monopoly protection of an occupational jurisdiction” (Evetts, 2011, p. 410).

Evetts (2011) provides a list of aspects of occupational professionalism, where “the development of strong occupational identities” is a named feature.

- Control of the work systems, processes, procedures, priorities to be determined primarily by the practitioner/s;
- Professional institutions/associations as the main providers of codes of ethics, constructors of the discourse of professionalism, providers of licensing and admission procedures, controllers of competences and their acquisition and maintenance, overseeing discipline, due investigation of complaints and appropriate sanctions in cases of professional incompetence;
- Collegial authority, legitimacy, mutual support and cooperation;
- Common and lengthy (perhaps expensive) periods of shared education, training, apprenticeship;

- Development of strong occupational identities and work cultures;
- Strong sense of purpose and of the importance, function, contribution and significance of the work;
- Discretionary judgement, assessment evaluation and decision-making, often in highly complex cases, and of confidential advice-giving, treatment and alternative ways of proceeding;
- Trust and confidence characterizing the relations between practitioner/client, practitioner/employer and fellow practitioners. (p. 411)

While Evetts considers *occupational* professionalism to be influenced by the “practitioners, users, states and universities”, *organisational* professionalism involves the employing organisation. This is a form of professionalism she aptly describes as professionalism constructed “from above” (Evetts, 2011, p. 408). “Accounts of change”, she says, “describe a shift from notions of partnership, collegiality, discretion and trust to increasing levels of managerialism, bureaucracy, standardization, assessment and performance review” (Evetts, 2011, p. 407). Associated with the introduction of neo-liberalism or new public management (NPM), changes to health and social service delivery, including the advent of the generic manager and a shift in the expectations of the patients (now consumers (DeMatteo & Reeves, 2013)) all contributed to this shift. “Thus, managerial demands for quality control and audit, target setting and performance review become reinterpreted as the promotion of professionalism” (Evetts, 2011, p. 412). It is noted that the health, psychological and social services professions which are the focus of this research, (with the possible exception of counselling) are typically employed in public organisations and thus typically subject to this type of control.

In the supervision literature two of the commonly named functions of supervision, the administrative/managerial and the educative (Kadushin & Harkness, 2002; Morrison, 1993) have long identified the dual accountability of supervisees (and supervisors) to profession-specific knowledge, standards and ethics of practice on the one hand and to the standards, philosophy, policies, ethics and service boundaries determined by the employing organisation on the other hand. The tensions between these two, sometimes competing, sources of expectations have been well documented in the supervision literature (Carroll, 2009a; Davys & Beddoe, 2010; Hughes & Pengelly, 1997; Proctor, 2001). Predating, or possibly anticipating, the changes wrought by NPM, Middleman and Rhodes (1980) capture the essence of this tension. “The supervisor-worker relationship” they say “is the key

encounter where the influence of organisational authority and professional identity collide, collude or connect” (Middleman & Rhodes, 1980, p. 52).

Supervision has thus long sat at the interface of the profession and the employer. It could equally be said that supervision has been, and continues to be, positioned in that space between occupational professionalism and organisational professionalism. In the practice of supervision, moreover, the tension between the requirements and values of the two is recognised, understood and addressed as a standard, and often recurring, item on the supervision agenda (Davys & Beddoe, 2010; Hughes & Pengelly, 1997; Wonnacott, 2012).¹

If professionalism defines the profession, the profession’s clinical practice, mores, ethics, knowledge, relationships and autonomy, then professional identity “the relatively stable and enduring constellation of attributes, beliefs, values, motives, and experiences in terms of which people define themselves in a professional role” (Schein, 1978, cited in Ibarra, 1999, pp. 764–765) can be considered to be the way in which the practitioner engages with and enacts the dictates of that professionalism.

Professional identity is commonly identified as an aspect of the professional self which is developed during the prequalification education process (Cruess, Cruess, Boudreau, Snell, & Steinert, 2015). From a sociological perspective Evetts (2003) describes this shared professional identity as a process of “occupational and professional socialisation” which is achieved through shared experiences of education, professional training, work experience and by “membership of professional associations (local, regional, national and international) and societies where practitioners develop and maintain a shared work culture” (p. 401). For Cruess et al. (2015) the development of professional identity for medical students and registrars is measured by their ability to “think, act and feel like a physician” (p. 718). Cruess et al. (2015) describe their process of teaching “medical professionalism” as a vehicle through which to assist medical students and registrars to develop their “own professional identity” (p. 718). Employing a developmental model, they describe the formation of professional identity as a staged journey where the person:

moves from self-centred conceptions of identity through a number of transitions, to a moral identity characterized by the expectations of a profession—to put the interests of others before the self, or to subvert one’s own ambitions to the service of society. (Bebeau, 2006, cited in Cruess et al., 2015, p. 718)

¹ Though, as noted earlier (chapter two), social work supervision in the United States is an exception and continues to be closely tied to organisational dictates.

What is important to note here is that, while professionalism defines the territory, there is an acceptance that each professional identity is different. Each student or registrar develops his or her own professional identity. Cruess et al. (2015) stress that professional identity “is not static and that the identity of a practicing physician will continue to evolve throughout his or her practice” (p. 720). Nevertheless such development continues to be shaped by and connected to the profession. According to Sutherland, Howard, and Markauskaite (2010) one of the four common characteristics of professional identity is that:

it is not a fixed entity, rather it is a process involving the interpretation and reinterpretation of experiences. A person plays an active role in the formation of his/her professional identity. This process, identity formation, is driven by the individual’s goal state of what he/she wants to become. (pp. 455–456)

In a study of the experiences of graduates and students in a preregistration interprofessional Masters level program, which aimed to conceptualize the social processes that constitute activities in IPE and collaborative practice, Green (2013) identified the concept of what he named “relative distancing in IPE”. Relative distancing he says “represents the strategies participants employ to construct their own professional identities and negotiate their way through interprofessional interactions” (Green, 2013, p. 36). Relative distancing according to Green’s study has four interrelated categories: “integrating the professional and the interprofessional, constellating and maintaining distance, tensioning and manipulating distance and the dimensions of distance” (Green, 2013, p. 36).

“Integrating the professional and the interprofessional”, from Green’s (2013) data, occurred in two ways. In the first, the interprofessional was accepted and integrated as a component of professional identity. The second was more comparative and selective where participants, exercising discretion, decided “how relevant the interprofessional was perceived to be” (Green, 2013, p. 36) before devoting resources to that area. “Constellating and maintaining distance”, the second category, refers to the process, within interprofessional settings where membership of a professional group enabled the participants to define themselves through formal, accepted and professionally endorsed “roles and responsibilities” (Green, 2013, p. 38). “Tensioning and manipulating distance”, by comparison, was where those roles and responsibilities established in category two, could be challenged and reconsidered. The fourth category, “dimensions of distance”, refers to what Green identifies as the “non-human elements” which shaped the engagement in IPE. These elements included the physical dimensions of space and materials, and the socially discursive dimensions of allegiance and hierarchy (Green, 2013, p. 39). Notwithstanding the occasions in category one, where the

interprofessional is understood as a component of professional identity, this study suggested that such integration is reasonably fragile and conditional. The students valued and accorded time to IPE activities according to the perceived value of those activities, “The choice of where to invest personal resources was based upon the perceived value of specific learning processes and outcomes” (Green, 2013, p. 40).

IPE experiences, as reported in the research, thus may need to be viewed with caution. While offering valuable insights, they are often of relatively brief duration and need to be considered in a developmental context where the presence of learning, assessment and striving to achieve professional competence and identity all interface with the interprofessional experience. Pollard, Miers, Gilchrist, and Sayers (2006) observe that since students are focussed on qualifying and gaining membership within their selected profession “logic dictates that the development of their own professional identity during undergraduate education involves adherence to the perceived values and ideals of their chosen profession” (p. 549). Similarly, Green (2013) speaking of students’ “emergent professional identity” refers to self-categorization theory, which he says “proposes that professional identity compartmentalizes, facilitating comparisons with others and that individuals will endeavour to enhance and protect their identities in order to generate self-esteem” (p. 40).

The protection of professional identity is identified as a critical factor in arguments which support same-profession supervision (Berger & Mizrahi, 2001; Crocket, Cahill, et al., 2009; Hair, 2013). These arguments propose a weakening of professional sovereignty and identification when supervisors do not share the professional knowledge, skills and practice orientation of the practitioners they supervise. When approached through a focus on difference, it is at the interface of the boundaries between professions where conflict arises “as different groups compete to assert their claims of expertise as professional knowledge and practice develops” (Cameron, 2011, p. 54). Professional identification, not only affects how professionals address problems but, more particularly, how they identify what is a problem. The possibility for disagreement increases in this space and Hudson (2002) concludes that “it is the scale and intensity of ‘disagreement’ that will shape interprofessional relations” (Hudson, 2002, p. 8).

Notwithstanding the challenges posed by the protection of professional identity and autonomy, Hudson (2007) offers hope. Reporting that the evidence in the literature on interprofessional working “tends towards pessimism rather than optimism” (p. 8), he challenges “some of the unduly pessimistic messages of the past” (p. 14). Identifying that reports of obstacles to and failure of, interprofessional working outweighed “accounts of

achievements” Hudson (2007) suggests that “a crossroads may now have been reached” (p. 3). One pathway confirms the inevitability of the failure of interprofessional working while the other pathway provides hope for new ways of working. From this Hudson (2007) proposes two contrasting models of interprofessional working: a pessimistic model and an optimistic model.

The pessimistic model is a model of exclusion rather than inclusion. It rests on the vested interests of distinctive professional identity, which include hierarchies of status (reflecting such issues as length of training, registration, and autonomy of practice (Hudson, 2007) and differentiated power and autonomy), and sets the scene for disagreement and conflict.

On the other hand, Hudson (2007) posits the existence of an ‘optimistic’ model of interprofessional working. Here the emphasis is away from difference and instead highlights the common ground or interest between professions. This side of the ledger identifies commonality of values, accountability, learning, location, culture and care. The central differences between the pessimistic and the optimistic models are characteristics of “distinctiveness” in the pessimistic model and characteristics of “commonality” in the optimistic model (Hudson, 2007, p. 4). Within the optimistic model, a key dimension describes commonality of learning. Here, Hudson describes a shift in professionalism. The model of old professionalism, he says, is characterised by: “mastery of knowledge, unilateral decision process, patient as dependent/colleagues as deferential, autonomy and self-management, individual accountability and self-management, detachment, and interchangeability of practitioners” (Hudson, 2007, p. 6).

By contrast, new professionalism features “reflective practice, interdependent decision process, (patient as empowered/colleagues involved), supported practice, collective responsibility, engagement, and specificity of practitioner’s strengths” (Hudson, 2007, p. 6). In this model the recognition of commonality creates the bridge which can span the silos of knowledge and which shifts the focus from practitioner/profession imperatives to service goals and consumer needs. Supporting the argument that professionals need to learn and to commit to learning as a lifelong process, Hudson (2007) asserts that “all professionals need to be aware of the importance of the plurality of knowledge, and be sufficiently confident of their own contribution and its limitations to allow for adjustment and negotiation” (p. 6).

The shift from old professionalism to new professionalism has similar characteristics to the shift required by practitioners and supervisors who engage in interprofessional supervision.

Without this shift practitioners would be hampered in their endeavours to practice supervision across professional boundaries.

Central to definitions of interprofessionalism, as identified earlier, is that people from different, separate or diverse professions work together. In recent decades however, and as introduced in chapter one, significant shifts have been reported in the understanding of what constitutes a profession and how professionalism is applied. This has led to Evetts' (2003) assertion that "it no longer seems important to draw a hard definitional line between professions and other occupations but, instead, to regard both as similar social forms which share many common characteristics" (p. 397). Professions are, she says, "essentially the knowledge based category of occupations which usually follow a period of tertiary education and vocational training and experience" (p. 397). Based on the work of Olgiati, Orzack, and Saks (1998) Evetts (2003) describes professions as being involved in:

birth, survival, physical and emotional health, dispute resolution and law-based social order, finance and credit information, educational attainment and socialization, physical constructs and the built environment, military engagement, peace-keeping and security, entertainment and leisure, religion and our negotiations with the next world. (p. 397)

Despite this broadened definition of professions and expanded understanding and acceptance of professionalism Evetts (2003), and possibly as a response to the urgency of global health policy and reform (Frenk et al., 2010), enquiry into interprofessionalism continues to be dominated by research which has been conducted in health, with an associated focus on the prequalifying IPE of health professionals. Little exploration of interprofessional work has taken place outside of the health services.

Research on Interprofessionalism

As mentioned earlier, interprofessional working has been an aspect of professional working for some decades, and its introduction into professional practice has been largely orchestrated through prequalification IPE and "post training professional education" (Ogletree, 2017, p. 159). Research into interprofessional working has thus generally either explored the experiences and perceptions of post qualified professionals who are operating within an interprofessional work environment, or has focused on the IPE experiences of students in prequalifying professional programmes. The research, however, has proved challenging. "Operationalising and measuring this multidimensional concept in real life has proven to be difficult" (Hepp et al., 2015, p. 134).

When interprofessionalism is accepted as a feature of professional health practice it is generally agreed in the literature that “the need to train health professionals who can work in interprofessional and multiprofessional teams is essential for effective, competent and culturally sensitive health care delivery” (Chipchase et al., 2012, p. 465) and “for enhancing communication and collaboration” (Martin & Manley, 2018, p. 41). World Health Organization (WHO) (2010) recommends IPE as a conduit for a collaborative practice-ready health workforce (p. 13). IPE they state “occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes” (World Health Organization, 2010, p. 13). The broad aims of IPE have elsewhere been described as being “to accomplish improved patient and population outcomes” (Pilon et al., 2015, p. 341).

Interprofessional Education.

Recent publications which focus on IPE include reports of research which explore and test the effectiveness of IPE and the insights gained by those involved. The studies commonly examine the experiences of mixed profession groups of prequalification students who are immersed in interprofessional learning experiences. In general, the studies identify the benefits of IPE, consider how these educational experiences will shape future interprofessional collaboration, and call for further research in the area.

Dolce et al. (2017) report on the practice based learning which resulted from an “interprofessional collaborative practice education program for nurse practitioner and dental students” (p. 405). The researchers identify the model, a blend of self-directed online learning, interprofessional collaborative practice-based learning and clinical rotations with dental students, as providing opportunities for collaboration and to improve health care. Gould, Lee, Berkowitz, and Bronstein (2015) explored the experience of medical and social work students who joined in working in geriatric care. They report that the students identified both the benefits of interprofessional collaboration and the “challenges to sustaining an interprofessional model in practice” (Gould et al., 2015, p. 373). Visser, Kusurkar, Croiset, ten Cate, and Westerveld (2019) interviewed 21 students from a range of professions which included medicine, nursing, pharmacy, and physical therapy following a three week placement on an interprofessional ward. Exploring the students’ experience from a motivational perspective they suggest that the IPE ward “enhance[s] students’ autonomous motivation for interprofessional collaboration (IPC)” (Visser et al., 2019, p.50). In an environment where the students were given responsibility for patients and opportunities for

interaction and discussion with their fellow students Visser et al. (2019) “conclude that it was the overall set-up of the IPE ward that enhanced the autonomy, not simply the responsibility or type of supervision” (p. 50).

Malcolm, Shellman, Elwell, and Rees (2017) meanwhile conducted a pilot study to examine a model for the integration of IPE and interprofessional care in a geriatric setting. Highlighting the importance of collaboration and cooperation between education and clinical settings, the study, Malcolm et al. (2017) assert, “demonstrated that interprofessional education and training in geriatric care can be implemented when academic institution and a hospital system partner with the ultimate goal of improving patient care” (p. 11).

Within the research on the interprofessional learning space of students, supervision is considered. In these studies, for the most part, professional supervision refers to the dictates enshrined in the traditions of individual and respective professions to determine its rationale and parameters. For many professions, particularly those in North America where supervision is frequently only a component of prequalifying education, rather than of ongoing practice, “understanding of the qualities and value of clinical supervision is based on uniprofessional clinical *education* [emphasis added] models” (Chipchase et al., 2012, p. 465). Noting the lack of research on interprofessional supervision within the educational space, Chipchase et al. (2012) examined the characteristics of interprofessional clinical supervision through the experiences of medical and allied health students and their supervisors. Their study, while indicating that interprofessional supervision was “beneficial and rewarding” (p. 465) to students, nevertheless found agreement amongst participants that ‘profession-specific’ supervision was also necessary. In discussion however, Chipchase et al. ponder whether students’ attitudes to interprofessional supervision may be as much a reflection of the cultural norms of the professional programme as a direct response to the experience of interprofessional supervision. They note that students maintained their need for same-profession supervision, even though they acknowledged that, in the absence of a same-profession supervisor, they found alternative ways to deal with situations.

Grace and Morgan (2015) studied complementary medicine students on placement in palliative care and rehabilitation wards in local hospitals in Australia, who were supervised by health professionals from different disciplines. Noting that the placements were not designed to “develop discipline-specific procedural skills”, Grace and Morgan (2015) found that the students developed four practice capabilities: “person-centered care, effective communication, multidisciplinary care, and professionalism” (p. 1). Identifying these practice capabilities as core, or central, to the practice of all health professions they suggest

that such capabilities may not be so easily developed through same–profession experiences which are often situated within profession specific competencies.

The interprofessional supervision experiences of occupational and speech language students on a rural placement in Australia were explored in a study by Yang, Nisbet, and McAllister (2017). Here, the findings emphasised the need for preparation of students before the commencement of interprofessional supervision sessions to counter the inaccurate assumptions which different students brought to the supervision. These assumptions, combined with a “devaluing of IP [interprofessional] supervision, when provided by someone perceived as inexperienced in IP supervision, intensified the participants’ desire for experienced IP supervisors and for DS [discipline–specific] supervision” (Yang et al., 2017, p. 12). Yang et al. (2017) thus also identified a critical need for interprofessional supervision training for supervisors. They concluded that these two factors, lack of student preparation and supervisor training “contributed to [students’] largely negative perceptions of interprofessional supervision resulting in the devaluing of interprofessional supervision now and possibly in the future” (p. 1).

In a related study which recognised this importance of supervisor training, Martin, Kumar, and Abernathy (2017) provided a series of nine workshops on interprofessional supervision to a group of 147 allied health nursing, medicine and dentistry professionals. The workshops which were designed to develop the participants’ “knowledge and skills in student supervision” (p. 134) were delivered by a team of professionals from a range of professions which included occupational therapy, psychology, dietetics and nutrition, and podiatry. Following the training Martin et al. (2017) reported an increase in self–reported confidence in student supervision, with 143 (97%) of the participants stating that they had “acquired new skills and knowledge from training” (p. 133) and 144 (98%) reporting their “intention to make changes to their practice” (p. 135).

Also with a focus on experienced professionals, Thomsgard and Collins (2003) employed a model of cross-disciplinary peer group supervision in a continuing education programme which aimed to improve communication between health and mental health care providers serving children and families. The nine group members, who included professionals from child psychiatry, paediatrics, nursing and psychology, took turns to facilitate the peer supervision sessions. This, the authors said, not only provided a model to minimise the differentials of status and power between the clinicians but also served as a model for clinician family relationships. The choice of a shared peer process, they reported, encouraged “participants to hear one another ‘thinking critically’ in the service of generating

a collaborative plan to reinforce strengths and overcome challenges in relationships” (Thomasgard & Collins, 2003, p. 307).

Previous research (Davys & Beddoe, 2008; Rains, 2007) has found a connection between ‘difference’ in the interprofessional learning context and the development of supervision skills. The participants in Davys and Beddoe’s (2008) study had all attended a supervision training programme where the students were from a range of professions. These participants considered that the mixed composition of the group enhanced their understanding of the practice of supervision and the development of the skills for becoming a supervisor. Because they were from different professional groups the participants reported being unable to make assumptions about other course members’ practice and this encouraged the development of their supervisory skills, specifically their ability to facilitate exploration and reflection. They were, in effect, forced to facilitate a reflective critique of practice because they were unable to ‘tell’ or give advice. The participants considered that difference in language and theory, far from being a disadvantage, helped to clarify their own thoughts and communication. In the words of one participant:

That’s the good thing about doing it with different professions because you can’t speak in the same language; you can’t, so you have to be clear about what you’re thinking about. You can’t get away with just, you know, you use jargon to flannel, you can’t do that. . . . And you have to speak English, so if you don’t understand what you’re talking about it’s going to show (Social Worker). (Davys & Beddoe, 2008, p. 64)

In such an interprofessional ‘supervision’ learning environment, shared professional identification, it could be said, is replaced by the ‘shared practice of supervision’ where the common purpose is to develop higher order supervision skills, which in turn facilitate practice exploration and professional critique. This shared practice of supervision is in line with Carroll’s (2007) description of supervision as “a profession in its own right with supervisors trained in coaching, individual and group supervision and organisational consultancy and is applied across professions” (p. 35).

The literature on IPE supports these experiences and suggests that “exposure to IPE (interprofessional education) forces students to experience ways of seeing the world that are different from their own” (Slavin, 1983, cited in Clark, 2006, p. 580). Interprofessional learning environments require students to think beyond their own profession and recognise the value and difference of other professions. In turn, successful work in an interprofessional environment, be it a practice environment or a supervisory environment, requires

sophistication of practice and a robust knowledge and acceptance of one's own professional strengths and limitations. It requires practitioners to have the ability to look outside their professional silo and to appreciate the difference and value of other professions and to look to the end goal and ask 'what is needed here?' For the practitioner it is to "fully understand the complexity of the professional world and take possession of his or her own, unique way of existing in it, while still valuing the perspectives and contributions of other professions" (Clark, 2006, p. 584). Townend (2005) suggests that attendance at a common training for cognitive behavioural training (CBT) may have drawn together some of the supervision pairs in his study. Though from different backgrounds, "they may have been drawn together because they share a common approach to practice through taking on a specific cognitive behavioural programme and thereby taking on its theoretical and practice values" (Townend, 2005, p. 587).

Interprofessional working.

Typically, when studying interprofessional working between experienced practitioners, models of care or interprofessional collaboration have been explored and/or evaluated. Some of these studies have been longitudinal. Selleck et al. (2017), recognising an emphasis in the interprofessional research "on the knowledge, skills, and attitudes of students or learners", instead explored the responses of experienced clinicians to the introduction of an interprofessional collaborative practice (IPCP) model, over a three year period. They reported on the "learning and understanding" that developed between these experienced clinicians who included participants from nursing, medicine, optometry, nutrition, mental health, social work and informatics (Selleck et al., 2017, p. 411). The faculty clinicians reported "mutual respect and admiration for complementary perspectives and unique contributions to the team... a greater awareness of [previously unrecognised] discipline-specific fields ... improved communication" and an "awareness of the importance of communication across disciplines" (Selleck et al., 2017, p. 414).

Fisher et al. (2017), also focussing on experienced clinicians, sought to describe the perceptions of the clinicians to IPCP and "to discover relationships between IPCP and patient/family satisfaction outcomes" (p. 96). Their findings indicated that whilst "overall interprofessional team collaborative practices" were present there was no correlation between IPCP and patient/family satisfaction outcomes (Fisher et al., 2017, p. 101). Meanwhile Chen et al. (2018) examined how the interactions and competence of the interprofessional team were perceived by caregivers and how satisfied the caregivers were

with the care provided. Their findings reinforced the importance of effective interprofessional team working and they reported “a strong positive correlation between caregivers’ ... scores and overall satisfaction” (Chen et al., 2018, para. 4) with the interprofessional team.

The importance or influence of workplace cultures, and the support of the wider organisation have also been identified in several studies as factors which can support, or hinder, interprofessional practice (Ketcherside, Rhodes, Powelson, Cox, & Parker 2017; Martin & Manley, 2018; Regan, Laschinger, & Wong, 2016). Stutsky and Spence Laschinger (2014) noted the lack of a validated conceptual framework to inform and support “knowledge of interprofessional collaborative practice (ICP)” (p. 1). The constructs from the conceptual framework which they subsequently developed from an extensive literature review and tested through a survey of 364 health care professionals, provided “encouraging preliminary empirical support for the conceptual framework with trust, cooperation, communication skills, and support structures predictors of ICP, and ICP a predictor of all outcomes identified in the framework” (Stutsky & Spence Laschinger, 2014, p. 1). In an aligned study Martin and Manley (2018), employing a Delphi survey across ten countries, identified “key qualities and skills facilitators need to support interprofessional teams to flourish and optimise performance” (p. 41).

Darracott, Lonne, Cheers, and Wagner (2019), recognising the tensions and conflict which interfere with effective interdisciplinary practice, surveyed 438 social care practitioners who represented social work, counselling and family therapy, psychology, nursing, social welfare and human services, child protection, and management, regarding the factors which those practitioners believed affected their practice. In particular, the researchers were concerned with the question as to whether there were “differences and similarities in the practitioners’ perceptions of influence and groupings based on profession, practice field, context of practice, or other practitioner demographics” (Darracott et al., 2019, p. 16). Their findings suggest that the factors which influenced the practice of those they studied were specific to practice context and not to broad groupings. These findings, they say, “challenge discipline-contingent discourses of difference among the various professions and suggest a common ground upon which enhanced relationships and interdisciplinary practice can be built” (Darracott et al., p. 32).

Other research has introduced, tested and evaluated tools or frameworks to organise and develop interprofessional knowledge and practice (Careau et al., 2015; Hasnain et al., 2017; Hepp et al., 2015; Pilon et al., 2015; Smith, 2015).

Notwithstanding the IPE opportunities and the associated promotion of interprofessional practice (IPP) the “translation [of IPE] to the workplace has produced mixed results” (McNeil et al., 2013, p. 291). For many, the transfer of IPE experiences to collaborative practice has been disappointing, particularly when considering the quality and outcomes of service delivery (Ketcherside et al., 2017; Lutfiyya et al., 2016; Martin & Manley, 2018; Wilson, Palmer, Levett-Jones, Gilligan, & Outram, 2016):

Despite a four-decade history of inquiry into IPE and/or collaborative practice, scholars have not yet demonstrated the impact of IPE and/or collaborative practice on simultaneously improving population health, reducing healthcare costs or improving the quality of delivered care and patients’ experiences of care received. (Brandt et al., 2014, p. 393)

Others note that there is limited available evidence or research in the area (Ketcherside et al., 2017; Pollard et al., 2006) while Sylvester et al. (2017), observing the “recent emergence of IPCP and complexities with its dynamic nature” conclude that “in truth, research considering the effectiveness of IPCP is in its infancy” (p. 207). Many questions remain unanswered and unexplored:

The challenge for the interprofessional community is to demonstrate empirically which forms of interprofessional education (IPE) are effective for that development in terms of when they take place (e.g. before or after qualification), where they occur (e.g. in classroom or clinical settings), how they are structured (e.g. as team projects or teamwork simulations), to whom they are delivered (which professions), by whom they are delivered (e.g. clinical or university facilitators), and why. (Thistlewaite, 2012, p. 59)

Interprofessional Supervision

It is apparent, when considering the complexity and interrelatedness of interprofessionalism, professional identity, professional status, professionalism and IPE as described so far, that interprofessional supervision cannot be regarded in isolation but must be viewed in broader political, organisational and professional context. The neo-liberal agendas, which led to major organisational restructuring and reshaping, may have been premised on cost reduction and a search for efficiency but paved the way for the introduction of new ways of working.

It is of interest to note that in the early years of interprofessional working in Finland, where it was reported that “collaboration in multidisciplinary teams [was] defective and problematic” (Paunonen & Hyrkäs, 2001) multidisciplinary clinical supervision was proposed as a means to “bring out the competence of the team, thus yielding the possibility

to gain synergy” (p. 293). In a more recent variation to this approach Kelly and Green (2019) suggest that in child protection (CP) settings, interprofessional supervision from an experienced social worker may help to develop effective interprofessional working by challenging and shifting dominant biomedical discourses and encouraging more reflective practice. The “inclusion of social work expertise in health-based CP services, through an interprofessional approach to supervision, can offer clarity to the operationalisation of supervision and support integrated service development” (Kelly & Green, 2019, p. 1).

Interprofessional supervision, in tandem with the developments of interprofessionality has thus also over recent decades emerged as an increasingly common and accepted mode of interprofessional working (Davys & Beddoe, 2015). However, whether a practitioner engages in interprofessional supervision, and whether (borrowing from Masterson (2002)), that practitioner regards it as a golden opportunity or threat to professional sovereignty may be a complex question. Engagement in interprofessional supervision can be a reflection of a combination of factors which include; organisational issues, professional expectations, political agendas with associated legislative requirements, the availability of appropriate supervisors or may simply be a matter of choice.

Four key factors can be identified as contributing to the increase in the practice of interprofessional supervision. The first three are interrelated and reflect major reforms within the health, psychological and social service sectors following the introduction of neo-liberalism or new public management (NPM).

First, consequent to this new political agenda, funding for service delivery of health, psychological and social services has become increasingly competitive and contestable which has led to cost cutting imperatives and significant restructuring (Berger & Mizrahi, 2001; Bogo et al., 2011; McCallin, 2001; Noble et al., 2016). This restructuring has resulted in the flattening of professional leadership and management positions and the decentralisation and regrouping of professional services under generic management and supervisory arrangements. In these situations same-profession supervision is not always assured (Berger & Mizrahi, 2001; Bogo et al., 2011; Globerman, White, & McDonald, 2002; Hair, 2013; O’Donoghue, 2004). In a more recent development in Britain, following the implementation of The Health and Social Care Implementation Taskforce, Brand (2015) predicts an increase in interprofessional working in health and social care. This, he says:

will necessitate skilled and knowledgeable interprofessional supervision. Supervisors will need to understand the values and expertise of different professions, know how

to promote co-operation and manage conflict, and ensure that the well-being of the individual is the priority of all. (Brand, 2015, p. 22)

Second, associated with, and in many instances contiguous with, organisational reforms and restructure is the promotion of interprofessional working as a ‘best practice’ principle to improve service delivery across professional silos (Hudson, 2002; Reeves, Lewin, Espin, & Zwarenstein, 2011). Despite a commentary on the difficulties of interprofessional work (Hudson, 2002; 2007; McCallin, 2001) where “interprofessional rivalries and turf wars are the rule rather than the exception” (Townend, 2005, p. 585), the literature reports that practitioners seek out and value interprofessional supervision which they see, amongst other things, as beneficial to the workings of the multidisciplinary team (Bogo et al., 2011; Crocket, Cahill, et al., 2009; Howard, Beddoe, & Mowjood, 2013; Hutchings et al., 2014; Mullarkey et al., 2001). A research participant explains how interprofessional supervision contributed to “more effective working within the multidisciplinary team through a greater understanding of others’ roles and responsibilities” (Townend, 2005, p. 585).

Third, the same time frames which have seen the imposition of reform and the promotion of interprofessional service delivery have also witnessed demands for increased reporting and measures for control. In this regulatory service environment health, psychological and social services have become increasingly accountable to both government (funders) and consumers for the services delivered and the management of risk has been given priority on organisational agendas. The government and the public require assurance regarding the standards for, and quality of, the work of health, psychological and social service practitioners, and legislation has been introduced which holds organisations, professions and individuals accountable. In Aotearoa New Zealand this accountability is evidenced through the provisions of such legislation as the Health Practitioners Competency Assurance Act (2003) and the Social Workers Registration Act (2003). In many instances health, psychological and social service organisations and professional bodies have seized upon supervision as a strategy of compliance and this in turn “has positioned supervision as a major vehicle for continuing professional development and the assurance of clinical competence of helping professionals” (Beddoe & Howard, 2012, p. 179). This strategy has included professions which had no tradition of supervision and therefore no existing pool of trained supervisors (Paulin, 2010). The contracting of supervisors from another profession has been identified as one way of meeting this new demand for competent supervisors (Beddoe & Howard, 2012).

This view however is not universally accepted. Crocket, Cahill, et al. (2009) argue that rather than breaking down the boundaries between professions, the regulatory environment, by requiring professions to clearly delineate their unique scopes of practice, has the potential to “heighten interprofessional rivalries and claims to hierarchy” (p. 26) and so reinforce the practice of supervision as a profession specific activity.

Finally, interprofessional supervision has become the supervision mode of choice for a number of individual practitioners (Beddoe & Howard, 2012; Cooper, 2006; Hutchings et al., 2014). Complex and diverse work situations require specialist approaches, and some practitioners find that they have supervision needs which are beyond the scope of the pool of available same profession supervisors. These practitioners, many of whom are autonomous practitioners and may be in private practice (Hutchings et al., 2014), seek to develop and enrich their levels of skills through supervision with supervisors with different expertise (Beddoe & Howard, 2012; Bogo et al., 2011; Cooper, 2006; Hutchings et al., 2014; Townend, 2005). At the practice interface this choice has also been influenced by the restrictions and conflicts of interest in small communities (Crago & Crago, 2002), which have led practitioners to seek supervision from supervisors of different professional backgrounds.

Research on Interprofessional Supervision

Previous research on interprofessional supervision has targeted four main areas:

1. Interprofessional supervision practice within specific professional groups (Beddoe & Howard, 2012; Berger & Mizrahi, 2001; Hair, 2013; Howard et al., 2013; Hutchings et al., 2014; Mullarkey et al., 2001; O’ Donoghue, 2004).
2. Interprofessional supervision practice in work or practice contexts, (Bogo et al., 2011; Cooper, 2006; Lambley & Marrable, 2013; Strong et al., 2004; Sweifach, 2017; Townend, 2005).
3. The attitudes towards, and/or experience of, the practice of interprofessional supervision by graduate practitioners from a range of professions (Cassedy et al., 2001; Crocket, Cahill et al., 2009; Shahmoon-Shanok & Geller, 2009; Simmons et al., 2007).
4. Supervision in multiprofessional teams (Hyrkäs & Appelqvist-Schmidlechner, 2003; Hyrkäs, Appelqvist-Schmidlechner, & Paunonen-Ilmonen, 2002).

The research methods employed have typically been exploratory qualitative interviews (Crocket, Cahill, et al., 2009; Hyrkäs et al., 2002; Lambley & Marrable, 2013), focus groups

(Bogo et al., 2011; Strong et al., 2004) and questionnaires and/or surveys (Beddoe & Howard, 2012; Berger & Mizrahi, 2001; Cooper, 2006; Globerman et al., 2002; Hair, 2013; Howard et al., 2013; Hutchings et al., 2014; Lambley & Marrable, 2013; Sweifach, 2017; Townend, 2005). Whilst most research targeted interprofessional supervision, some studies which explored the general supervision experiences of specific groups of professionals have recorded the incidence of interprofessional supervision within these professional groupings (Berger & Mizrahi, 2001; Bogo et al., 2011; Cooper, 2006; Hair, 2013; Lambley & Marrable, 2013; Strong et al., 2004; Sweifach, 2017; Townend, 2005).

The key findings of previous research detail the following elements, to be discussed below: the incidence of interprofessional supervision, the benefits of interprofessional supervision, the concerns and the satisfaction of supervisees, reasons for choosing interprofessional supervision, supervisor competence, and cautions raised in relation to interprofessional supervision.

Incidence of interprofessional supervision.

The incidence of interprofessional supervision across professions is difficult to ascertain as different studies target different populations. Some studies focus on the experiences of practitioners who were at the time engaged in interprofessional supervision, whilst others examine the supervision practice of specific work contexts or specific professional groups.

Social work, a profession with a strong preference for same-profession supervision, is the most researched group. One of the earliest studies (Berger & Mizrahi, 2001) surveyed hospital based social workers in the United States of America on three occasions over a five year period between 1992-1996. In the context of health reforms they sought to determine patterns of supervision and, although the numbers of those engaged in interprofessional supervision were small, they demonstrated a steady increase in the number of social workers accessing this form of supervision; 12% in 1992 to 19% in 1996. A similar increase was seen in the numbers of social workers for whom interprofessional supervision was the only supervision they received (7% in 1992 and 10% in 1996). Globerman et al. (2002), in an overlapping study (1995-1999), of senior hospital social workers in Canada found that this group rarely had access to same-profession supervision.

More recent surveys of social workers show a growing trend towards interprofessional supervision. Hair (2013), exploring the experiences of social workers from a range of practice contexts in Canada, reports that 36% were engaged in an interprofessional supervision arrangement. At the same time Hair reports that her respondents made a strong

call for same-profession supervision. Meanwhile, in Aotearoa New Zealand, Hutchings et al. (2014), surveying social work practitioners, found that 25.9% of social work practitioners received interprofessional supervision, 29.6% of social work supervisors provided interprofessional supervision and a total of 44.5% were both providing and in receipt of interprofessional supervision. Of particular interest is the finding that 84.2% of supervisees were also engaged in same-profession supervision. Beddoe and Howard (2012) targeting social workers and psychologists who were in current interprofessional arrangements, made a similar discovery. Of their 423 respondents, 63.6 % of the psychologists and 52.2% of the social workers also accessed same-profession supervision. On the other hand, Townend (2005), surveying mental health cognitive behavioural therapists from a wide range of professions in England, reports that whilst 40% were engaged in interprofessional supervision, only 1 respondent was also in same-profession supervision.

Benefits of interprofessional supervision.

The benefits of interprofessional supervision have been reported to include the development of deeper and richer levels of skill (Beddoe & Howard, 2012; Bogo et al., 2011; Hutchings et al., 2014; Shahmoon-Shanok & Geller, 2009; Townend, 2005), improved critical thinking and the opportunity to introduce more creativity into practice (Beddoe & Howard, 2012; Bogo et al., 2011; Hutchings et al., 2014; Townend, 2005). Interprofessional supervision was considered to help guard against complacency (Townend, 2005) and to challenge assumptions of practice (Crocket, Cahill, et al., 2009; Hutchings et al., 2014). The critique provided by an external eye on practitioners' work was valued as was the ensuing increased understanding of other professional perspectives (Crocket, Cahill, et al., 2009; Howard et al., 2013; Hutchings et al., 2014; Townend, 2005). Some practitioners identified interprofessional supervision as a means to address the historical legacy of hierarchical modes of supervision (Rains, 2007). In the work context, interprofessional supervision was reported to be helpful to multidisciplinary work through the development of better relationships between professionals and a greater understanding of different roles and responsibilities (Crocket, Cahill, et al., 2009; Howard et al., 2013; Hutchings et al., 2014; Hyrkäs et al., 2002; Mullarkey et al., 2001; Thomasgard & Collins, 2003; Townend, 2005).

Concerns of supervisees.

Concerns, however, have also been voiced. Many of these concerns focus on the lack of common professional knowledge and context and include: the management of difference in terms of experience, knowledge, skill base and language (Bogo et al., 2011; Howard et al.,

2013; Hutchings et al., 2014; O'Donoghue, 2004; Strong et al., 2004; Sweifach, 2017; Townend, 2005), the lack of knowledge, and awareness, of new profession-specific developments (Bogo et al., 2011), the management of risk and lack of awareness of, and therefore adherence to, specific professional ethics and codes of practice (Beddoe & Howard, 2012; Crocket, Cahill, et al., 2009; Howard et al., 2013; Hutchings et al., 2014; Simmons et al., 2007; Townend, 2005). Some practitioners reported feeling anxious in interprofessional supervision contexts and fearful of revealing weaknesses (Howard et al., 2013; Hutchings et al., 2014; Townend, 2005) whilst others were aware of differential status between professions and consequent feelings of disempowerment (Howard et al., 2013; Hutchings et al., 2014). Bernard and Goodyear (2009) and Mullarkey et al. (2001) identify a more fundamental risk to the development and maintenance of professional identity, while Strong et al. (2004) note the fear of the “devaluing of the specific skills” of certain disciplines and the subsequent creation of an opening for the introduction of a generic worker (p. 202). Berger and Mizrahi (2001) meanwhile comment on the potential for ‘clinical isolation’ (p. 14) and ‘erosion of clinical competency’ (p. 2). In the social work profession, which has a long history of mandated same-profession supervision, deep concern has been registered regarding the practice of interprofessional supervision. Berger and Mizrahi (2001) declared that “the growth of supervision by non-social workers is setting off alarms for many practitioners and leaders” (p. 13), and Hair (2013) described it as a demonstration “that professional erosion is widespread” (p. 1583).

Satisfaction of supervisees.

Despite the misgivings about the ability of interprofessional supervision to deliver effective supervision (Berger & Mizrahi, 2001; Hair, 2013), studies which have explored practitioners’ experiences of this mode of supervision record positive levels of satisfaction. Howard et al. (2013) report the average score for satisfaction across the two disciplines, social work and psychology, which they surveyed as “very satisfied” (p. 35), whilst Hutchings et al. (2014) record that, overall the social work participants in their study were positive about the “level of effectiveness” of the supervision they received (p. 59). Townend (2005) found that interprofessional supervision was very common in his sample of cognitive behavioural therapists (CBT) with 40% of the participants engaging a supervisor of a different profession. He reports that the difference in professions had minimal effect on the supervision provided. Fifty nine percent of the supervisees considered that the difference of profession “never got in the way” and 26% considered that it “rarely got in the way” (Townend, 2015, pp. 584–585).

Two perspectives emerge as influencing the satisfaction derived from interprofessional supervision. The first perspective attributes the value of the interprofessional supervision to the supervisor's ability to promote good practice and facilitate learning, in other words, the supervisor's ability to supervise. In this view the professional orientation of the supervisor was not as important as his or her attributes, focus and skills as a supervisor (Howard et al., 2013).

The second perspective, although not disputing the importance of the quality of the supervisor's knowledge and skills, found value in the very fact of difference. As noted earlier, many of the benefits identified by research participants centred on the value of the 'other', the differences of knowledge, skills and perspectives.

Reasons for choosing interprofessional supervision.

A factor which emerges from the research is the matter of choice. Interprofessional working, driven primarily by political and organisational imperatives (Bogo et al., 2011; Hudson, 2007), has been largely imposed on to practitioners. Interprofessional supervision however is commonly reported as the supervision mode of choice for practitioners and reflects supervisees' wish to match their supervisory needs with the attributes of the supervisor (Beddoe & Howard, 2012; Cooper, 2006; Howard et al., 2013; Hutchings et al., 2014). Howard et al. (2013) in their study of social workers and psychologists who participated in interprofessional supervision found all supervisees exercised choice in their supervision relationships. Over 52% of the supervisees chose their supervisor because of that person's knowledge and skills, 42.9% because of the supervisor's understanding and knowledge of the work context, 34.3% because of a lack of available or appropriate supervisors in their own profession and 22.9% because of a previous positive relationship with that person (Howard et al., 2013, p. 33).

In an earlier study, which explored the elements of good supervision, Davys (2002) interviewed social work supervisees who rated the quality of the supervision they were engaged in to be four or five on a one to five scale (five indicating excellence). All of the six supervisees who participated in the study chose their supervisor. These choices were based on: "the knowledge and skills of the supervisor, prior knowledge of the person and inter-personal factors" (Davys, 2002, p. 85). Interestingly, at a time when interprofessional

supervision could be said to be in its infancy, two of the five² supervisors chosen were from a profession other than social work.

As a chosen relationship the participants in interprofessional supervision would appear to regard difference as an opportunity rather than as an obstacle. Studies have reported a high incidence of social work practitioners choosing interprofessional supervision despite, as mentioned earlier, the profession's general preference for same-profession supervision (Beddoe & Howard, 2012; Hair, 2013; Hutchings et al., 2014). In some instances this supervision was in addition to same-profession supervision and for some practitioners it was the only supervision they received (Beddoe & Howard, 2012; Hutchings et al., 2014):

When choice is possible there is a view that experienced practitioners benefit more from the challenge and stimulation of a new approach rather than gravitation towards the familiar. (Scaife, 2009, p. 19)

Supervisor competence.

The skills, knowledge and competence of the supervisor were themes throughout the reported research. Cassidy et al. (2001) described the provision of cross discipline group supervision to new supervisors (p. 198), where from a “background in mental health, human relations, counselling and training” (p. 199) two of the authors provided group supervision to a group of general nurses. An initial preference, commonly held by the supervisees for a supervisor who shared their profession and background, was attributed by the authors to feelings of vulnerability within the group and a need for the safety. The authors continued however that “as knowledge and experience is gained supervisees gradually realise there is a greater opportunity for development in choosing someone, irrespective of his or her background, who will stretch them and be more challenging” (Cassidy et al., 2001, p. 200). The authors concluded with the belief “that it is more important for the supervisor to be competent in and understand the process of supervision, than it is to share the same clinical background to the supervisee” (Cassidy et al., 2001, p. 200).

Bogo et al. (2011) reported similar findings. Focusing on volunteer clinicians from a range of professions in a mental health context in Canada they reported that:

supportive, clinician-focused, content-oriented supervision offered by knowledgeable and skilled clinical experts was perceived as beneficial, regardless of the supervisor's profession. Supervisors' expertise regarding the client population and effective

²One of social work supervisors was nominated twice.

interventions as well as their ability to promote learning and a sense of competence for clinicians, emerged as highly valued. (p. 135)

The supervisees in this study however at the same time “expressed a need to discuss profession-specific issues and learn about new trends” (Bogo et al., 2011, p. 133).

Rather than a reflection of supervisor competence, interprofessional supervision has elsewhere been seen as a challenge for supervisors. Hyrkäs and Appelqvist-Schmidlechner (2003) studied five multiprofessional teams, which included “medical doctors, unit and assistant unit sisters, specialized nurses, nurses, assistant nurses, secretaries and other auxiliary staff” (p. 191). They noted the challenges posed by the need for the supervisors to both clarify the wide understanding of “multiprofessional team supervision and collaboration” (p. 195) which individual supervisees brought to the team supervision while at the same time managing varied dynamics within the teams:

Team members’ perceptions of the feeling of togetherness varied. Communication had become more open in the teams, but the frankness of expression varied: communication had generally become more tactful, whereas in one of the teams frankness offended some members. Team members had learned to know each other. This had improved mutual understanding, but also increased tension. (Hyrkäs & Appelqvist-Schmidlechner, 2003, p. 188)

Cautions about interprofessional supervision.

Finally, the literature cautions that interprofessional supervision is not, or should not be, the mode of supervision for everyone and provides recommendations for interprofessional supervision practice.

These recommendations include the need for familiarity with each participant’s professional codes, values, ethics (Berger & Mizrahi, 2001; Hutchings et al., 2014; O’Donoghue, 2004; Simmons et al., 2007; Townend, 2005), knowledge of each participant’s training and practice experience (Hutchings et al., 2014; O’Donoghue, 2004; Townend, 2005), the acknowledgement of, and subsequent addressing of, difference in status between participants (Beddoe & Howard, 2012; O’Donoghue, 2004; Townend, 2005) and clarification and agreement regarding the theoretical framework used in practice (Berger & Mizrahi, 2001; Crocket, Cahill, et al., 2009; Townend, 2005). It is generally agreed that new graduates and practitioners new to a work context are best supervised within their own profession (Beddoe & Howard, 2012; Bogo et al., 2011; Crocket, Cahill, et al., 2009; Mullarkey et al., 2001; Simmons et al., 2007). There is also recommendation that interprofessional supervision is

additional to same-profession supervision (Beddoe & Howard, 2012; Berger & Mizrahi, 2001; Hutchings et al., 2014; Lambley & Marrable, 2013; O'Donoghue, 2004; Simmons et al., 2007; Strong et al., 2004). Finally, it is recommended that care is taken to develop, implement and regularly review a supervision agreement or contract (Beddoe & Howard, 2012; Crocket, Cahill et al., 2009; Hutchings et al., 2014; O'Donoghue, 2004; Simmons et al., 2007).

The literature thus reports a mixed response to interprofessional supervision as a mode of supervision practice. Interprofessional supervision is the mode of choice for many participants and supervisees report being satisfied with the supervision which they receive. The benefits of interprofessional supervision are recorded and it is noted that interprofessional supervision is congruent with interprofessional working contexts. Conversely, concerns are expressed, and alarm sounded, regarding its potential to erode professional identity and to fail to provide safe and accountable practice. More questions are asked than have been answered and, in this contradictory mix, there appears to be “no unified understanding” of what defines interprofessional supervision (Hutchings et al., 2014, p. 59).

Conclusion

The complexity of interprofessional working is evident from this review of the literature and research. Interprofessionality has challenged and disturbed the boundaries of traditional professions (and occupations) and the traditional ways of working. The literature records the effects of this and the ways in which professions, and individual professionals, have attempted to reconcile these changes while at the same time maintaining their identity as a professional in their field of practice. Interprofessional supervision is an aspect of interprofessional working and these complex interprofessional relationships, often based on hierarchies of status and influence sit at the heart of any interprofessional supervision arrangement.

The following chapter, chapter four, presents the research methodology of this study.

Chapter 4: Methodology

“Qualitative research is not a linear process. Research question(s), method(s) and even theories all feed into, and inform, each other, and there are many routes to research design” (Braun & Clarke, 2013, p. 43).

This research is situated within a social constructionist epistemology, employs qualitative research methodology and is sequential in design.

The sequential design and the different decisions which were required at each of the phases of the research present a degree of complexity to the organisation of this chapter. To address this complexity and to provide some order to the discussion, chapter four is organised into six sections. In section one the rationale for the choice of epistemology and research methodology is considered. Section two presents an overview of the four phase sequential research design. In section three participant selection, or sampling, is discussed and the rationale for the choice of sampling technique is provided. This section also includes the different selection decisions which were made at each phase of the research. Section four repeats the process of section three but this time describes the method and decisions of data collection, again with reference to each of the four phases.

Section five, which details the manner in which thematic analysis was employed as the method for data analysis, is again divided into three parts. First, thematic analysis is discussed. Second, the way in which this was conducted in the research is described and, finally, the analysis at each phase is reviewed. The different decisions made during the analysis process are illustrated through tables. The chapter concludes with consideration of the ethical issues, constraints and the limitations of the research.

Epistemology and Methodology

Two broad epistemological positions are commonly found in social science research. The first, positivism, closely aligned to empirical physical science, holds to the belief of an objective, discoverable truth (Crotty, 1998). By contrast the second, constructionism, views meaning as “not discovered but constructed” (Crotty, 1998):

Constructionist epistemologies argue that the world and what we know of it do not reflect an ‘out there’ true nature of the world... waiting to be discovered but that what we know of the world, and ourselves and other objects in the world is constructed (produced) through various discourses and systems of meaning we all reside within. (Braun & Clarke, 2013, p. 30)

The primary aim of this research, as introduced in chapter one and described in more detail later in this chapter, is to explore, describe and map the ways in which the participants of interprofessional supervision work with each other and engage in supervision practice. The research thus considers how the participants of interprofessional supervision understand and conduct the practice of supervision between people from different professions. Each participant in interprofessional supervision, the supervisor and the supervisee, brings to the supervision relationship and to the ensuing supervision conversation a range of beliefs, values and attitudes which are shaped by personal life experience, experience of professional practice and by the dictates and practice mores of their individual professions. At the interface between professions, where difference is a constant factor, interprofessional supervision requires both parties to construct understanding and to negotiate pathways to safe and ethical practice. As noted in chapter three, professionals in interprofessional relationships need “to be aware of the importance of the plurality of knowledge, and be sufficiently confident of their own contribution and its limitations to allow for adjustment and negotiation” (Hudson, 2007, p. 6).

Social constructionist epistemology, which is underpinned by the belief that “reality is co-constructed between the researcher and the researched and shaped by individual experiences” (Creswell, 2013, p. 36), was considered to be congruent with the perspectives brought to interprofessional supervision as discussed above, and was thus chosen for this study. Social constructionism, it is believed, provides the flexibility for the inclusion of different and multiple views brought to the research by both the participants and the researcher and creates a basis from which these can be examined and co-constructed into new understanding and meaning. It is considered to be well suited to the research question, providing both the depth of exploration of the participants’ situations and also an opportunity to address the “processes of interaction among individuals” (Creswell, 2013, p. 25).

Constructionist researchers, as Creswell (2013) notes above, are engaged in the co-construction of meaning with those who are being researched. Researchers thus, he continues, “make an interpretation of what they find” (p. 25) and recognise “that their own background shapes their interpretation, and they ‘position themselves’ in the research to acknowledge how their interpretation flows from their own personal, cultural and historical experiences” (Creswell, 2013, p. 25). The researcher’s personal positioning and the assumptions which accompany this position, detailed in chapter one, are acknowledged as a component in the construction of the experiences reported in this research.

The choice of methodology and methods of any research project is influenced by the ability of that methodology and of those methods to fulfil the purpose of the research and to answer the research questions (Crotty, 1998, p. 2). Warning of a common tendency in research projects to conflate these two terms Braun and Clarke (2013) provide the following distinctions. “Method refers to a tool or technique for collecting or analysing data ... Methods are quite specific and applied in specific ways. Methodology is broader, and refers to the framework within which our research is conducted” (Braun & Clarke, 2013, p. 31). Methodology, Braun and Clarke (2013) continue, helps to direct decisions about such things as participant selection, methods of data collection and analysis and the appropriateness and role of the researcher (p. 32).

Two paradigms, the qualitative paradigm and the quantitative paradigm, are typically described in relation to social research. A paradigm, as defined by Braun and Clarke (2013), “refers to the beliefs, assumptions, values and practices shared by a research community ... and provides an overarching framework for research” (p. 4). Expanding on their most basic distinction that qualitative research “uses words as data” while quantitative research uses “numbers as data” (Braun & Clarke, p. 3), Braun and Clarke (2013) provide the following definition. “Qualitative research, as we define it, is not just about data and techniques – it’s about the application of qualitative techniques within a qualitative paradigm” (p. 4).

Qualitative research is “exploratory, open-ended and organic, and produces in-depth, rich and detailed data from which to make claims” (Braun & Clarke, 2013, p. 21). On the basis of this definition qualitative methodology was chosen as the best methodology through which to gather the detailed and different experiences of the professionals who are engaged in interprofessional supervision, to understand what meaning it has for their professional role and to map how that meaning is enacted in practice.

Research design

The purpose of this study is to consider interprofessional supervision as a separate and distinct mode of supervision practice. The primary aim to explore, describe and map the ways in which the participants of interprofessional supervision work with each other and engage in supervision practice is underpinned by a number of research questions which have been assembled into two groups: context and practice. The formulation of specific questions was iterative, influenced by the literature on interprofessionalism and difference and also shaped by the gaps which have been identified in the current research in the field of interprofessional supervision.

When exploring the context of interprofessional supervision, three questions are posed:

1. How do different professions articulate their recommendations, cautions or requirements with regard to interprofessional supervision?
2. How do health, psychological and social service practitioners access interprofessional supervision, what incentives and constraints do they encounter and what choice do they have?
3. What values, knowledge and beliefs about themselves, about their profession and about supervision, underpin practitioners' decisions to engage in interprofessional supervision?

When exploring the practice of interprofessional supervision, four further questions are asked:

4. How is difference identified and managed in the interprofessional supervision relationship?
5. What tasks, processes or activities are particular to this mode of supervision?
6. How does difference affect the supervision process and outcome for the participants?
7. How do the participants of interprofessional supervision describe the difference between interprofessional supervision and same-profession supervision?

In this four-phase study, phase one considers the context for the research whilst phases two, three and four are sequential. Employment of this sequential design “allows sequential interim analyses and decision making based on cumulative data and previous design decisions” (Bovaird & Kupzyk, 2010) and as such provides flexibility which allows phases two and three to inform and shape both the data collection and the analysis of each subsequent phase. In phase four, the combined findings from phases two and three were presented back to the original participants of phase two for comment and critique. These comments and the critique contributed to the co-construction, between the participants and the researcher, of a Map for Interprofessional Supervision (see Figure 4.1). The research was thus inductive in that the theory was generated from the research (Bryman, 2012). As described by Bryman (2012), this type of research is “relatively open ended and emphasises the generation of concepts and theories but does not entail (among other things) the iterative style of grounded theory” (p. 422).

As appropriate to qualitative research, qualitative techniques and qualitative methods of data collection and data analysis were employed. Participants were recruited to the research

through purposive sampling, while semi-structured interviews, audio recording (a variation of simple observation (Bryman, 2012³)) and member reflections⁴ were the methods used for data collection. Thematic analysis as “a means for identifying themes and patterns of meaning across a dataset in relation to a research question” (Braun & Clarke, 2013, p. 174) was employed to analyse the transcripts from the interviews and the observations. In the final phase of the research a combination of thematic analysis and descriptive analysis were used. The sampling, data collection and data analysis will each be fully discussed later in this chapter.

³ Situations in which the observer has no control over the behaviour ... and plays an unobserved, passive and non- intrusive role in the research situation” (Webb et al., 1966 quoted in Bryman, 2012, p. 325).

⁴“Member reflections allow for sharing and dialoguing with participants about the study’s findings, and providing opportunities for questions, critique, feedback, affirmation, and even collaboration (Tracy, 2010, p. 844).

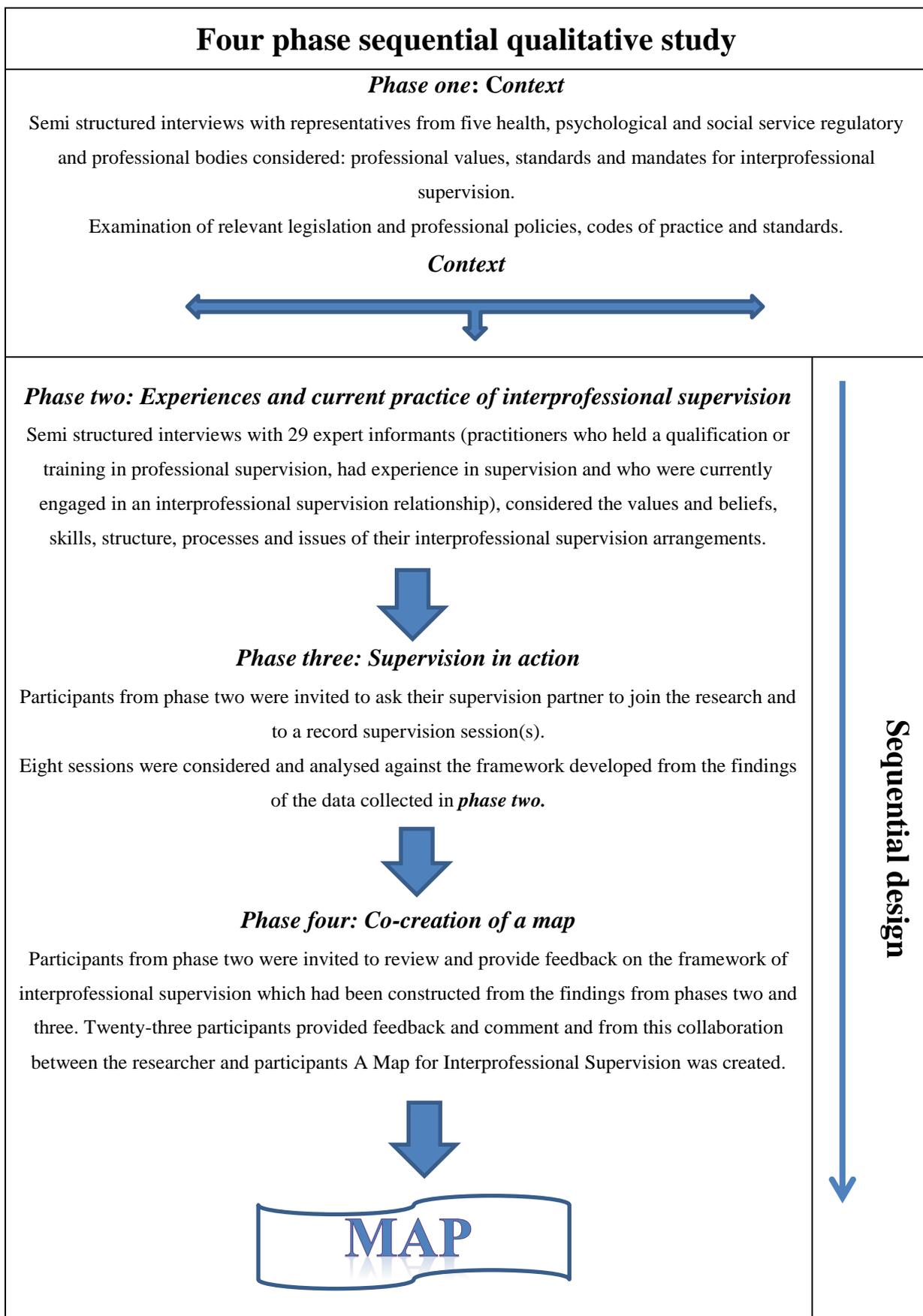


Figure 4.1. Overview of the Research Design.

Phase 1: Context.

Phase one of the research focused on the legislative and professional context for the practice of interprofessional supervision. Findings from the perspective of representatives from five health, psychological and social service regulatory and/or professional bodies (New Zealand Association of Counsellors (NZAC), New Zealand Psychologists Board (NZPB), Nursing Council of New Zealand (NCNZ), Occupational Therapy Board of New Zealand (OTBNZ), and Social Workers Registration Board (SWRB)), presented a broad view of the research ‘problem’ which added complexity to the data and provided, what Creswell (2013) describes as, a holistic account (p. 47).

A review of relevant legislation (Health Practitioners Competence Assurance Act 2003 (HPCA Act)), Social Workers Registration Act, 2003 (SWR Act)), and the regulatory and/or professional body (Aotearoa Association of Social Workers, (ANZASW), NZAC, NZPB, NCNZ, OTBNZ, SWRB), codes of practice, competencies, expectations and requirements for supervision of the five professions, supported the data collected from the interviews. This examination of the differences and similarities of professional policy between each profession helped to define the parameters of the territory within which interprofessional supervision is located in this study. The study sits within a unique context. Interprofessionality considers the parameters of each profession but gives paramourncy to none. The boundaries of the territory described in turn identified the ‘space’ within which difference must be understood, managed and negotiated. Phase one provided the context in which the interprofessional supervision, explored in phase two, occurred.

Phase 2: Experiences and current practice of interprofessional supervision.

Phase two engaged the views of 29 expert informants regarding their experiences and practice of interprofessional supervision and the values and considerations which influenced their decision to choose a supervision partner from a different profession to their own.

Phase 3: Supervision in action.

In phase three the recording and analysis of eight ‘live’ supervision sessions occurred. Participants from phase two were invited to ask their supervision partner to join this third phase of the research. These interprofessional supervision partnerships or dyads (supervisor and supervisee) recorded live supervision sessions onto a digital audio recorder. The analysis of these recordings was considered alongside the data from phase two and formed the basis of the preliminary findings presented to the participants in phase four.

Phase 4: Co-creation of a map.

Finally, phase four invited all the participants of phase two to review and critique, utilising member reflections, a framework of interprofessional supervision which had been developed from the findings of the previous phases, two and three.

The inductive reasoning process of qualitative research Creswell (2013) notes:

Involves researchers working back and forth between the themes and the data base until they establish a comprehensive set of themes. It may also involve researchers collaborating with the participants interactively, so that they have an opportunity to shape the themes or abstractions which emerge from the process (p. 45).

The participants of phase four were presented with a preliminary framework of interprofessional supervision which had been developed by the researcher following analysis and integration of the findings from phases two and three. Through member reflection (Tracy, 2010) the participants collaborated with the researcher to provide feedback and additional comment to refine and to develop this framework.

The review and feedback from phase four resulted in the creation of a Map for Interprofessional Supervision. This map of interprofessional supervision, the outcome of this sequential research, presents the theory generated from this inductive research (Bryman, 2012).

Participant Selection

Two population groups were represented in this research: regulatory and professional bodies, and professional practitioners. Purposive sampling, which involves the enquirer selecting “individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon in the study” (Creswell, 2013, p. 156), was employed. Two types of purposive sampling, criterion sampling and snowball sampling, were utilised.

Criterion sampling which “allows interviewees to be selected purposively in terms of criteria that were central to the main topic of the research” (Bryman, 2012, p. 423) was employed in both phases one and two. Snowball sampling, a “technique in which the researcher samples an initially small group of people relevant to the research questions, and these sampled participants propose other participants who have the experience or characteristics relevant to the research” (Bryman, 2012, p. 424), was employed to supplement the participants in phase

two. The sampling strategies of each phase of the study will be discussed in more detail later in this section.

Purposive sampling, Creswell (2013) notes, is commonly used in qualitative research as a strategy to address different levels of data. He recommends that more than one level of sampling is employed. In this research purposive sampling accessed three levels of data across the two populations, regulatory/professional bodies and practitioners. At the level of *site* or context, the views and mandates of different regulatory and/or professional bodies regarding interprofessional supervision (phase one) were recorded. The *participant* level was sampled in phase two through the views of expert informants and finally the recorded supervision sessions of phase three provided sampling at the *event or process level* (Creswell, 2013, p. 156). Phase four, where the findings are presented back to the participants of phase two, can be regarded as criterion sampling (all participants had experienced the phenomenon of being engaged in the earlier phase) at participant level.

Appropriate sample size for qualitative research is debated within the literature (Braun & Clarke, 2013; Bryman, 2012; Creswell, 2013). Bryman (2012) notes that it can be difficult at the outset to determine an appropriate sample size, but emphasises that the sample “needs to be able to support convincing conclusions” (p. 424). This will, he says, vary from situation to situation and he concedes that it is “a delicate balancing act” (Bryman, 2012, p. 424). Five interviews with representatives of five purposively selected regulatory or professional bodies were conducted in phase one to provide context and overview. The larger sample sizes in phase two (29 participants) and phase four (23 participants) of the research provided breadth to the data collected, while the eight sessions observed in phase three provided depth and detail demonstrating the specifics of interprofessional supervision practice. “The intent in qualitative research is not to generalise the informationbut to elucidate the particular, the specific” (Creswell, 2013, p. 157).

Phase 1: Context.

As the research question in this study addresses the interface between professions it was relevant to the context of interprofessional supervision practice (and hence to the research) to establish a baseline from which to understand the profession-driven attitudes and mandates regarding supervision practice and the legislation which underpins them. As a ‘site’ the regulatory and professional bodies are important in that they influence the culture and expectations of the individual professions and hold responsibility for the standards and competencies of specific professional practice. Representatives from the regulatory and/or

professional bodies of five health, psychological and social service professions, purposively selected for context (Bryman, 2012, p. 417), were interviewed to consider the values, beliefs and mandates which are held by each profession regarding interprofessional supervision.

The bodies approached to be included in the research were NZAC, NZPB, NCNZ, OTBNZ and SWRB. A letter was sent via email to the chair, registrar or executive officer of each of those bodies inviting them, or their representative, to participate in an interview (appendix 1). All of the bodies approached agreed to take part in the research. The five professions were selected on the basis that they represented a range of positions on variables such as the mandate for supervision, registration of the profession, legislation under which the profession operates and supervision expectations. The variables are discussed in further detail in chapter five. These particular professions were also selected because practitioners from these professions have been identified in previous research (Beddoe & Howard, 2012; Berger & Mizrahi, 2001; Crocket, Cahill, et al., 2009; Hutchings et al., 2014; Townend, 2005) as participants in interprofessional supervision.

At the outset of the research it was considered possible that the expert informant group (phase two) might include participants from professions other than the five selected. If this had been the case additional interview(s) would have been included in phase one. In the event however all of the participants in phase two, with exception of one participant from the unregulated workforce, aligned with the identified professions.

When considering and developing the research design it was initially proposed that, because the counselling profession in Aotearoa New Zealand was unregulated and in order to provide uniformity, interviews should be conducted with representatives from each professional body. After reflection this design was amended, with the exception of NZAC, to only include interviews with relevant regulatory bodies. When a profession is regulated it is the regulatory body which holds specific authority, conferred via the underpinning legislation, to ensure among other things standards of practice. The counselling profession is not registered and accordingly the professional body carries the responsibility to ensure the quality and the standards of practice of counsellors as a form of internal regulation⁵. In instances where the profession is regulated the corresponding professional body generally holds a different relationship to its members, membership may not be mandatory and the expectations tend to be based on professional, rather than political or legislative norms.

⁵ In October 2017, during the period when this research was being conducted, the membership of NZAC voted in favour of adopting a new process of self-regulation which would come into effect in 2019. This is further discussed in chapter five.

Phase 2: Experiences and current practice of interprofessional supervision.

In order to explore, describe and map the ways in which the participants of interprofessional supervision worked with each other and engaged in supervision practice, the researcher wished for participants to have both practical and theoretical knowledge of professional supervision. This knowledge and experience were considered necessary to provide a base from which to elicit conversations which were informed by an understanding of supervision theory, research and best practice.

Initial criteria for participation in the research therefore required the practitioners to be graduates of professional supervision programmes delivered by two different tertiary institutions. The two particular institutions, in separate cities, were chosen in order to provide variation in geographic sample and also variation in terms of programme content. Two other factors also shaped this choice. First, as both programmes offered enrolment to practitioners from a range of professions, the theory and skills of supervision were taught within an interprofessional context and it was reasoned that there would be synergy between their learning experience and their interprofessional supervision practice. The second, more pragmatic, reason was that, as the two institutions were within a geographical region accessible to the researcher, the participants in the research would be more readily available for interview.

Graduates of a graduate or postgraduate professional supervision programme, delivered by either the University of Auckland or by the Waikato Institute of Technology (Wintec), were invited to participate (purposive sampling). A call for participants to join the research was sent to graduate practitioners through existing professional networks and was advertised in University of Auckland and Wintec partnership newsletters and communications (appendix 2). The invitation and advertisement invited recipients to alert other practitioners to the research (snowball sampling). To be included in the research as expert informants, participants were required to meet two criteria. First that they held a graduate or postgraduate professional supervision qualification from either named institution and second that they were currently engaged in interprofessional supervision. The informants in this phase could be either supervisors or supervisees. Purposive sampling in this case aimed to select informed and expert participants who would add value to the research through experience, training and currency of practice.

Following initial recruitment however, only fourteen graduates from these programmes had volunteered and been accepted as participants. It became evident too that the alumni data

bases from the two institutions were not necessarily up to date and that the communication networks did not sufficiently target the breadth of professions required for this research. Snowball sampling (Bryman, 2012), the opportunity for graduates to invite other colleagues with relevant experience to join the research, however, did introduce additional potential candidates. At the same time, the criterion that participants hold a supervision qualification from the University of Auckland or Wintec was a limiting factor. Many potential recruits did have a supervision qualification but not from the specified tertiary providers, whilst others had supervision training and experience but no qualification. Overall, Braun and Clarke (2013) state, the research sample needs to be “appropriate to [the] research question and theoretical aims of the study, and provide “an adequate amount of data to fully analyse the topic and answer [the] question” (p. 55). In order to provide rich data participants needed to 1) have knowledge about supervision, 2) have experience of supervision and 3) be in an interprofessional supervision relationship. It therefore became clear that the type of qualification or training and the place where that qualification/training took place, were not important. Taking a sequential approach “where sampling is an evolving process in that the researcher usually begins with an initial sample and gradually adds to the sample as befits the research questions” (Bryman, 2012, p. 418) the criteria for inclusion into the research was amended permitting participants with other qualifications, training and experience in supervision to be accepted. Selected through this combination of criterion and snowball sampling, twenty-nine expert informants were recruited to this phase.

Phase 3: Supervision in action.

Participants of phase two, expert informants, were invited to participate in phase three of the research (appendix 3). As actual live supervision sessions were to be recorded in phase three, participants were required to invite (snowball sampling) their supervision partner. Participation in phase three was contingent on consent by that supervisor (or supervisee).

This variation of snow ball sampling was intended to not only expand the research group but also to add depth to the material studied as it was likely that it would include supervision partners who were outside of the original selection criteria.

In this phase of the research between ten and twenty transcripts of live supervision practice were ideally wanted for analysis in order to provide depth and breadth of data. The number of supervision sessions which each dyad (supervisor and supervisee) would be asked to record was therefore to be determined by the number of dyads who agreed to participate. Six dyads volunteered for this phase and recorded a total of eight sessions. Although this was not

the ideal desired number of sessions it was considered that eight sessions would provide sufficient range of supervision. Two dyads provided two sessions while the other six provided one session each.

Participant Information Sheets for phases two and three, provided to all the participants, included an overview of the research design. They were alerted to the invitation to join the fourth phase of the research. Unwillingness or inability to participate in phase four was not a barrier to participating in phase three. As is detailed later however, due to the low number of participants in phase three and due to the geographical spread, recruitment into phase four of the research was altered. Invitations to contribute to phase four were extended to all of the participants of phase two. No supervision partners from phase three volunteered to participate in phase four.

Phase 4: Co-creation of a map.

Originally, phase four intended that a preliminary interprofessional supervision framework, developed from the findings of phase two (reports) and phase three (observation), would be explored through focus group interviews with the participants of phase three. In this forum, these participants were to be invited to collaborate in the co-creation of a map of interprofessional supervision. The low number of participants in phase three, and the broad geographical area from which they came, however made it impractical to hold the proposed focus groups for phase four. An alternative process was designed and appropriate ethical consent was obtained.

Invitations were extended, through email to all 29 participants from phase two of the research, to contribute to phase four by providing feedback and comment on the framework developed from the findings of the two earlier phases (appendix 4). Twenty seven participants replied to the initial email request, one acknowledging the invitation but declining the opportunity to contribute due to other commitments.

Participants who returned their feedback and comments through email went into a draw for a \$50.00 Westfield voucher⁶. Braun and Clarke (2013) note that incentives and payments for participation in research is a “thorny issue” (p. 60). For some, payment is believed to change the research process introducing a financial element into what otherwise could be seen as an altruistic act. Others, they note, argue that payment is a valid way to reimburse research

⁶The process for drawing the winner was independent of the researcher. Names of the eligible participants were put into a paper bag and the winner was drawn from the bag by one of the researcher’s supervisors.

participants for their time and effort. In this research the voucher was used to provide an incentive to participants to answer and return the requested feedback and comments.

Whether it was due to the incentive of the voucher or the novelty of the task, of the 26 participants who agreed to participate, 23 completed the task and provided feedback and comment. Of the three who did not complete, one withdrew following technical difficulties and two did not return further response.

Data Collection

Three data collection methods, as mentioned earlier, were employed in the research: semi-structured interviews, a variation of simple observation, and electronic member reflection. All interview data collected were digitally recorded and transcribed and the variation of simple observation (audio recordings) were similarly transcribed. The electronic member reflection participants returned written comment and feedback via email or email attachment.

Phase one, positioned to establish a broad context for the practice of interprofessional supervision, was the first step in the research but was not part of the sequential design. Phases two, three and four, however, were sequential and the collection of data at phases three and four was dependent on the completion of the collection and the analysis of the data in the preceding phase.

Semi-structured interviews, employed in phases one and two, were chosen to provide structure to the interviews and at the same time allow “for the participants to raise issues that the researcher has not anticipated” (Braun & Clarke, 2013, p. 78). Whilst most of the data collection was obtained in face-to-face interviews, where both the participants were in the same room, the geographical location of some participants required alternative data collection means. Eight of the participants were accordingly interviewed using the electronic medium of Skype. One participant was interviewed via telephone when the Skype connection failed. As noted, whilst offering the same contact as face-to-face interviews, there are additional advantages of using the internet (webcam and Skype) to collect qualitative data (Bryman, 2012; Creswell, 2013). These advantages are found in efficiencies of time, cost and travel and in offering more flexibility and space for participants to consider their responses.

All of the interviews, face-to-face, Skype and telephone were audio recorded with the MP3 Skype recorder being used to record the skype interviews. All of the transcripts were transcribed. On completion of the interviews the researcher uploaded the digital files onto the University of Auckland Dropbox system and notified the transcribers who accessed the

system and downloaded the files. On completion of the transcription the transcriber emailed the typed transcript, as an attachment, to the researcher's University of Auckland email account.

The employment of a variation of simple observation (phase three), and electronic member reflection (phase four) collection methods is detailed in the following description of data collection at each phase.

Phase one: Context.

Interviews, all of approximately 40 minutes duration, were conducted with representatives from NZAC, NZPB, NCNZ, OTBNZ and SWRB. The interviews were semi-structured with five demographic questions and seven open ended questions. The interviewees were provided with a copy of the interview questions (appendix 5). Three of these interviews were conducted face to face and two were conducted via Skype.

A review of the relevant legislation (HPCA Act, 2003; SWR Act, 2003), and professional policies, codes of practice and standards (ANZASW, NZAC, NZPB, NCNZ, OTBNZ and SWRB) was also conducted in phase one to provide the broader context and mandate for the supervision of the five professions in Aotearoa New Zealand.

Phase two: Experiences and current practice of interprofessional supervision.

In phase two a total of 29 interviews were conducted with the expert informants who had consented to participate. This comprised 22 face-to-face interviews, six Skype interviews and one interview through telephone connection. The interviews, semi-structured with eight general demographic questions, eight general questions concerning supervision and seven open ended questions, ranged from between 60 and 90 minutes in duration. The interviewees were provided with a copy of the interview questions in advance of the interview (appendix 6).

The focus of the interviews included: participants' experience of interprofessional supervision, the values or beliefs which have influenced their choice of interprofessional supervision and the benefits, challenges and cautions regarding interprofessional supervision. They were asked to describe what processes, skills and structures they employed to bridge the differences which they encounter, or may encounter, in supervision across professions. Finally they were asked to identify how, if at all, interprofessional supervision differs from same profession supervision for them.

Phase three: Supervision in action.

The purpose of phase three was to collect data which represented the natural and everyday processes and exchanges of interprofessional supervision. The data collection method therefore needed to be as unobtrusive as possible and the use of a digital audio recorder was thought to be the best way to meet this requirement. Audio recording, when the researcher is not present, in part meets the criteria described for simple observation. Simple observation, as defined by Webb et al. (1966, cited in Bryman, 2012) “plays an unobserved, passive and non-intrusive role in the research situation” (p. 325). The presence of an audio recorder in a supervision session can be described as passive, the extent to which it is unobserved and non-intrusive is less certain. Clearly, the participants in the supervision sessions were both aware of the audio recorder as they had given their consent to allow the session to be recorded and had provided the means (generally a mobile phone) to record the session. The supervision sessions which were recorded were part of the scheduled supervision sessions arranged by the supervision pairs and were conducted in their usual venue. As such, the setting was routine and the session was pre-planned. Whether, and to what extent, the presence of a recording device was an intrusion or distraction is difficult to say, though no mention of the recorder was noted in any of the transcripts of the sessions. The data collection method has been named as a *variation* of simple observation.

Following the recording of the supervision session the participants sent the recording to the researcher as an electronic attachment to an email or used a drop box facility. This proved to be easy for some and for others posed problems. Several participants enlisted the technical assistance of colleagues in their places of work. A total of eight recordings were provided.

Phase four: Co-creation of a map.

The final method of data collection, employed in phase four, has been termed *electronic member reflection*. Member reflections “enhance qualitative credibility in several different ways, going far beyond the goal of ensuring that the ‘researcher got it right’” (Tracy, 2010, p. 844). They may introduce new perspectives which deepen analysis and “as such, member reflections are less a test of research findings as they are an opportunity for collaboration and reflexive elaboration” (Tracy, 2010, p. 884). As considered by Tracy, member reflection is understood as a face to face experience. This research however used an electronic format and hence it has been renamed *electronic member reflection*. A more detailed account of electronic member reflection is given at the end of this section.

As described earlier the geographic spread of potential phase four participants made the proposed use of focus groups problematic. While it is possible to create on-line focus groups (Braun & Clarke, 2013; Creswell, 2013) there are a number of difficulties which accompany this mode of communication which can interfere with the discussion. The first difficulty can be to coordinate meeting times with participants where they can access a suitably equipped computer in an appropriately private or quiet location. More critical is the management of technical problems. Varied strength of internet connections combined with a range of computer capacity and technology can result in uncertain connections accompanied by poor sound and video relay which can be frustrating and distracting for both participants and researchers. In the face of these problems it was decided to abandon the focus groups and instead to ask participants to provide critique and feedback on written material which would be sent via email. Informal communication from one of the potential participants, however, stating that “I would much rather hear you talk about it than just read it”, indicated that solely written material might not suit everyone.

At this time the researcher viewed a conference presentation which had been prepared using VideoScribe, and saw this as a creative supplement to written material. VideoScribe, whiteboard animation software, enables a combination of written word, pictures, animation and voice recording to produce a presentation. Arts-based research, as defined by Jones and Leavy (2014), is “any social research or human inquiry that adapts the tenets of the creative arts as a part of the methodology (p.1)”. The use of such creative methods Vaart, Hoven and Huigen (2018) note, have often been used in conjunction with qualitative research approaches to provide richness and nuance to the data. In this research, it was also thought that the animated framework presented via video would introduce novelty and might encourage participants to agree to engage in this phase of the study. It was also understood that the potential members of the participant group were busy individuals. Accordingly it was considered important to provide as short a presentation as possible. The resulting 8 minutes and 20 seconds video, though longer than the five minute target, was nevertheless a tight presentation and summary. While this method of data collection has much in common with a self-administered questionnaire (Bryman, 2012) the research request that the participants watch a short video extended and added depth to the data collection method.

All participants of phase two of the research were sent an email outlining the new research process and were invited to participate (appendix 4). The task was outlined and an estimate of 30 minutes was given as the time it would take to complete the task. The email recipients were asked to indicate their interest by return email. On receipt of a response the researcher

emailed a second email (appendix 7) which provided the detail of the task, the questions, a written summary of the framework (appendix 8) and an electronic link which enabled the participants to download the video (video transcript Appendix 9) from the University of Auckland Dropbox.

The participants who agreed to engage were able, through the electronic link, to access the brief 8 minutes and 20 seconds video which they were asked to watch. The video presented the findings from phases two and three in the form of a *framework of interprofessional supervision*. The phase four participants' critique and feedback on this framework were shaped by four open-ended questions and additional comment was encouraged. Participants emailed their responses to the researcher.

The participants effectively had a period of two weeks within which to reply as access to the video, provided through the University of Auckland drop box, expired after 14 days. Two days prior to the expiry of the drop box link those participants who had not responded were emailed to remind them of the expiry date. Eleven participants requested more time to respond and the video was reloaded for a further 14 days. Creswell (2013) comments that one of the advantages of qualitative data collection via the internet is that "it provides participants with time and space flexibility that allows them more time to consider and respond to requests for information" (p. 159).

The responses to the questions were returned electronically, either as an email or as an email attachment in the form of a word document. This data was then collated into a single document by the researcher.

Whilst holding some similarity to *member checking*, defined by Braun and Clarke (2013) as the "practice of checking your analysis with your participants" (p. 282), the *member reflection* employed in this study introduced a process which was considerably broader. The purpose was not to check the analysis of individual contributions but rather to comment on the analysis of data sets which had been produced through phases two and three, and to contribute to the construction of a final map of interprofessional supervision. Participants, Tracy (2010) observes, will not necessarily agree with a researcher's analysis and they may have a range of responses which are variously motivated. Member reflections, as a research method are thus congruent with constructionist epistemology which understands that there will be multiple constructions and variations of any one phenomenon. Tracy (2010) concludes:

The researcher has very little control over participants' reactions or the ways research is eventually evaluated or used. However, they do have control in providing the space and option for member reflections, and in doing so, provide opportunities for additional data and elaboration that will enhance the credibility of the emerging analysis. (p. 844)

Data Analysis

As introduced at the start of this chapter, this section on data analysis is presented in three parts. First, a discussion of methods employed to analyse the data is given. Second, an overview of the way in which the methods of analysis were employed in the research is detailed. Third, the analysis is considered at each phase of the research.

Methods employed.

Researchers, from their immersion in qualitative data, “emerge with new perspectives, new linkages, new understandings and theories” (Rice & Ezzy, 1999, p. 190). It is accepted and noted here that the findings which ‘emerge’ from the analysis of this qualitative research represent an interpretation of the data which is shaped by the researcher’s own subjective and theoretical understandings. These understandings, held by the researcher, are presented in chapter one.

Thematic analysis, compatible with the constructionist paradigm (Braun & Clarke, 2006), was selected as the most appropriate method of analysis for all of the four phases of this research. Interprofessional supervision has not been extensively researched and it was considered that thematic analysis would provide a method which would enable more depth and breadth of ideas to be noted and explored. Described as “a method for identifying, analysing and reporting patterns (themes) within the data” (Braun & Clarke, 2006, p. 79), thematic analysis is also considered to be able to provide a systematic and flexible way of organising data sets within the whole body (data corpus) of the research (Braun & Clarke, 2006). Different approaches to thematic analysis can be used within one study for different outcomes. As such, this method of analysis was seen to be able to provide sufficient flexibility to address the requirements of each sequential phase of this study. In phase four descriptive analysis was also used in combination with thematic analysis. Defined as “a semantic approach to analysis which aims to investigate, document and describe the nature of some issue” (Braun & Clarke, 2013, p. 329), descriptive analysis in tandem with theoretical thematic analysis were chosen as the best methods to support the collaborative and critical intent of this phase.

Two approaches to thematic analysis were employed. Theoretical thematic analysis, described as “driven by the researcher’s theoretical or analytic interest in the area, and ... thus more explicitly analyst driven” (Braun & Clarke, 2006, p. 84) was used to analyse the interviews with the regulatory and professional body representatives in phase one in order to provide a baseline context for interprofessional supervision. The analysis of phase one data was shaped by the researcher’s interest in how interprofessional supervision was regarded, supported or blocked by regulation, policy or interpretation of policy and/or legislation. In phase two, the second approach to thematic analysis, was used. Inductive thematic analysis where analysis is “a process of coding the data without trying to fit it into a pre-existing coding frame, or the researcher’s analytic preconceptions” (Braun & Clarke, 2006, p. 83), enabled the building of a broad range of themes from the participants’ reports of their interprofessional supervision practice.

The analysis of data from phase three, though ultimately shaped by the findings from phase two using theoretical thematic analysis, initially employed inductive thematic analysis to analyse the exchanges and the processes between the supervision partners. The transcripts of the supervision sessions were analysed to identify themes within each (dyad) ‘set’ of transcripts (inductive analysis), which allowed thematic comparison between the ‘sets’. The whole data set from phase three was then considered, using theoretical thematic analysis, against the framework developed from the data analysis of phase two. The researcher focused on how the audio recordings reflected or differed from the accounts of interprofessional supervision reported in phase two.

Together these findings were presented, as a preliminary framework of interprofessional supervision, for consideration by the participants in phase four. Here, theoretical thematic analysis in combination with descriptive analysis, were considered as the most appropriate methods of analysis. Theoretical thematic analysis provided the means to order the feedback while descriptive analysis provided the best way to note particular feedback, the participants’ critique and their suggestions for change. Descriptive analysis as Braun and Clarke (2013) say aims to “give voice” (p. 173). The use of this method of analysis allowed the participant’s individual critiques to be both noted and heard.

The level at which the themes are to be identified presents a further area for decision. Identifying two levels, ‘semantic’ and ‘latent’, Braun and Clarke (2006) distinguish between them. The semantic level is where the themes are “within the explicit or surface meanings of the data” (p. 84). At the latent level, however, the researcher “goes beyond the semantic content of the data, and starts to identify or examine the underlying ideas, assumptions, and

conceptualizations and ideologies that are theorized as shaping or informing the semantic content of the data” (Braun & Clarke, 2006, p. 84). Both of these levels were employed in the present study; the semantic level for phases one, three and four and the latent level for phase two and, in combination with the semantic level, in phase three.

To determine the question of what constitutes a theme in this research, Braun and Clarke (2013, p. 337) are again consulted. A theme, they say, is “a patterned meaning across a data set that captures something important about the data in relation to the research question, organised around a *central organising concept*”. Importantly, Braun and Clarke (2016), critiquing the literature on thematic analysis, emphasise that in their view of thematic analysis themes are not pre-existing entities waiting to be discovered or captured but rather themes are “actively crafted by the researcher, reflecting their interpretative choices” (Braun & Clarke, 2016, p. 740). Themes are thus created not found.

The data analysis choices made for this research are summarised in Table 4.1.

Table 4.1. Data Analysis Decisions

<i>Decisions</i>	<i>Phase one</i>	<i>Phase two</i>	<i>Phase three</i>	<i>Phase four</i>
<i>What is a theme</i>	“a patterned meaning across a data set that captures something important about the data in relation to the research question, organised around a <i>central organising concept</i> ”. (Braun & Clarke, 2013, p. 337)			
A rich description of the data set <i>or</i> a detailed account of one particular aspect	A detailed account of one particular aspect	A rich description of the data set	A detailed account of one particular aspect	A detailed account of one particular aspect
Inductive <i>or</i> theoretical thematic analysis	Theoretical thematic analysis	Inductive thematic analysis	Inductive and Theoretical thematic analysis	Theoretical thematic analysis and Descriptive analysis
Semantic <i>or</i> latent themes	Semantic	Latent	Latent and Semantic	Semantic
Essentialist/realist <i>or</i> constructionist thematic analysis	Constructionist thematic analysis			

(Braun & Clarke, 2013, pp. 82–85)

“The analysis of qualitative data generally only begins once all data have been collected” (Braun & Clarke, 2013, p. 204). Apart from phase one, where the data were collected from regulatory and professional body representatives, a population group which was separate from the population group of the subsequent three phases, the sequential design of this

research led to a staged process of both data collection and analysis. The participant group of professional practitioners (expert informants) of phase two could potentially be involved in each of the two subsequent phases (three and four). Data collection for phases three and four was thus shaped by the analysis of the previous phase(s) and could not proceed until that data had been analysed.

The data from each phase of the research was coded using NVivo, a computer-assisted qualitative data analysis software package (CAQDAS), to assist analysis. That there is debate within the qualitative research community regarding the use of CAQDAS is noted in the literature, (Braun & Clarke, 2013; Bryman, 2012) but there is also a reminder that the “analyst must still interpret his or her data, code and then retrieve that data” (Bryman, 2012, p. 591). The CAQDAS takes over some of the previous, cutting, pasting, colour coding (Bryman, 2012; Creswell, 2013) and “such programmes only offer a tool to assist with coding and analysis” (Braun & Clarke, 2013, p. 220).

The analysis of the data is summarised in Table 4.2 using headings, suggested by Braun and Clarke (2013, p. 202), to describe the process of coding and analysis. These headings are: transcription, reading and familiarisation, coding, searching for themes, reviewing themes, defining and naming themes, writing and finalising themes. An overview of the process is presented followed by an account of the issues encountered at each phase.

Overview of methods employed.

Central to data analysis is familiarisation with the data (Braun & Clarke, 2006; 2013). The analysis of recorded data of this research occurred separately for each phase and the material was reviewed in several ways. First, although the audio material was independently transcribed, the researcher also listened to the audio recordings. Though this has been named as the first step there was however no particular pattern to this listening, sometimes it was prior to reading the transcript, sometimes it was after reading the transcript and at others times it occurred at a point of interest during the reading of the transcript.

Second, the transcripts were printed onto hard copy and carefully read. At times notes were jotted in the margins when a point of interest or a recurring idea was presented. A second more focused reading clustered these ideas, more notes were made and sections highlighted. A separate page noted the ideas. Third, the transcripts were read electronically and passages, with reference to the hard copy notes were highlighted. Fourth, the electronic transcript was uploaded onto NVivo and through a fourth reading the transcript was coded into NVivo producing codes and sub codes. The scale of this coding process varied depending on which

phase of the research was being analysed. Phases one and three for example had sample groups of five and eight respectively whilst phase two had 29 participants.

Following this coding, the codes and the sub codes were surveyed with the question “so what does this mean?” The codes were reworked. Some minor codes were joined with others whilst others were renamed and formed different categories. At all times the researcher endeavoured to hold certain questions in the fore. These included: “How does this data inform me of how the participants of interprofessional supervision work with each other and engage in supervision practice?” “What does this tell me about the beliefs and values which underpin this practice?” “How is difference perceived and managed?”

Tentative themes were organised at this point and the transcripts revisited to test and support these preliminary themes. Care was taken to avoid a common trap and ensure that the theme was indeed a theme and not a collection of responses to a question posed by the researcher (Braun & Clarke, 2006, p. 85). Following a test run with the data the themes were confirmed and named. Table 4.2 summarises the analysis process.

Table 4.2. Analysis Process

Stages	Phase one	Phase two	Phase three	Phase four
Transcription	All recordings independently transcribed	All recordings independently transcribed	All recordings independently transcribed	Not applicable Data collected in electronic written form
Reading and familiarisation	Audio recording listened to, transcriptions read electronically and hard copy for familiarisation and passages of interest highlighted	Audio recording listened to, transcriptions read electronically and hard copy for familiarisation and passages of interest highlighted	Audio recording listened to, transcriptions read electronically and hard copy for familiarisation and passages of interest highlighted	Data collected electronically. Collated onto a word document and read both electronically and on hard copy for familiarisation and passages of interest highlighted
Coding. Identify codes and provide a label for a feature of the data that is potentially relevant for answering the research question. Researcher derived codes	Following familiarisation, using NVivo software 10 primary codes 15 sub codes were created	Following familiarisation, using NVivo software 17 primary codes (9 of which had sub codes) From which 45 sub codes were created	Not so much interested in the content as the overall shape and form. Accordingly three guiding categories were established to assist coding <i>Context:</i> 18 codes <i>Process:</i> 20 codes – one sub code <i>Structure:</i> 8 codes	Data reported against the questions posed.
Searching for themes Meanings not numbers	Searching the identified codes for patterns of response and meaning	Searching the identified codes for patterns of response and meaning	Codes were explored across the data set and incidence and similarities noted and recorded	Feedback grouped into themes
Reviewing themes	Four themes were constructed	Three themes constructed	Checking/reviewing findings of phase two. Three themes constructed	Themes woven into the framework of the four questions
Defining and naming themes. Good themes are distinctive and need to make sense on their own	Attitudes to interprofessional supervision; Developmental readiness for interprofessional supervision; Factors which may shape a choice for interprofessional supervision; Quality supervision and professional boundaries.	Choice and the development of the professional self; Interprofessional supervision: a structured process; Diversity as a vehicle for learning.	Relationship; Professional practice; Managing the difference.	Feedback and critique collated into a revised framework
Writing- finalising analysis		Phase two analysis and findings chapter completed before analysis of phase three	Phase three analysis and findings chapter completed before analysis of phase four	<i>A Map for Interprofessional Supervision</i>

Phase one: Context.

The purpose of phase one of the research was to establish a context for the practice of interprofessional supervision through interviews with representatives of five health, psychological and social service regulatory and professional bodies.

Theoretical thematic analysis was conducted as described above using NVivo and early patterns were recognised. Review of this data and the themes, however, revealed that it did not fulfil the required purpose of this phase of the research which was to provide a clear and detailed legislative and professional basis from which to understand interprofessional supervision practice in Aotearoa New Zealand. The interviews provided rich and useful perspectives regarding the approaches and attitudes of the different professions but were not sufficient to present the higher order requirements. It became clear that an examination of the legislation and the documentation of each board/association was important. The interview data was therefore supported by a review of relevant legislation and professional codes which detailed the mandates and expectations of the selected professions and their practice of supervision. Against this background information, which provided a baseline for the practice and mandate of supervision for the different professions, four themes (discussed in chapter five) were constructed from the interview material:

- Attitudes to interprofessional supervision;
- Developmental readiness for interprofessional supervision;
- Factors which may shape a choice for interprofessional supervision;
- Quality supervision and professional boundaries.

Phase two: Experiences and current practice of interprofessional supervision.

The inductive thematic analysis, employed in phase two, provided a broad lens, less shaped by the researcher's questions, through which to view the data. The analysis process is well described by Braun and Clarke (2016):

... coding and theme development processes are organic, exploratory and inherently subjective, involving active, creative and reflexive researcher engagement. The process of analysis - rigorous coding followed by a recursive process of theme *development* – involves the researching 'tussling with' the data to develop an analysis that best fits their research question (p. 741)

From the viewing and reviewing of the coding of the data three themes (to be discussed in detail in chapter six) were constructed.

- The role of professional identity and the developing of the professional self;
- Interprofessional supervision: defining the territory;
- Diversity as a vehicle for learning.

Phase three: Supervision in action.

The analysis of the transcripts of live supervision in phase three employed both inductive thematic analysis and theoretical thematic analysis. Initially the transcripts of the supervision sessions were reviewed using inductive thematic analysis. The analysis process described earlier was followed allowing a view and review of the data. The questions which the researcher posed for herself at this stage of this analysis were broad looking for latent themes. For example, what were the patterns of these sessions? How was relationship presented? How could these supervision exchanges be described? Having considered the transcripts from this wider view the researcher wished to tighten the focus.

Three broad codes were constructed to assist with the organisation of the components of supervision as practised: structure, content and process (to be discussed in detail in chapter seven). The *structure* considered the way in which the supervision session was conducted, what tasks or activities occurred and in what order. The *content* identified the broad subject matter or focus of the supervision conversation, whilst the *process* was concerned with the way in which the supervisor conducted the conversation, what skills and interventions she or he used in the session. From these broad codes, sub-codes were organised.

Having organised the data in this way the transcript from each dyad session was viewed to consider the codes as represented in each session and this in turn was compared against the transcripts of other dyads across the data set. When the codes had been reviewed, refined and confirmed across the data set, using theoretical thematic analysis, three themes were constructed: relationship, professional practice, managing the difference.

The analysis of phase three concluded with a table which presented characteristics, which underpinned the themes, from both phase two and three (described in chapter seven). Examples were provided of how these characteristics were evident and congruent across both data sets. These findings were then integrated to provide a *framework of interprofessional supervision* which was to be presented to participants in phase four for critique and feedback.

Phase four: Co-creation of a map.

Unlike the previous three phases, where the data were collected by audio recording, the data collected in phase four were in written form and sent electronically as an email or as an email attachment to the researcher. The data collection method of electronic member reflections aligned with the intent of phase four to give voice to the participants' views on the material presented and to provide an opportunity for co-creation. In order to provide integrity to the feedback from the participants, a preliminary ordering of the data, according to the questions posed, preceded the analysis.

Descriptive analysis, it was considered, provided the best means to note and record the individual feedback and critique of the participants and their suggestions for change. The ordering of the analysis according to the four questions, it was believed, gave fidelity to this process. Within each question, however, particular responses were grouped, using theoretical thematic analysis, as themes and these were recorded as such. The data within each question grouping was subjected to the same process of coding, review and revision as the previous phases.

The analysis of phase four data thus was ordered by the four questions:

1. How well does the framework reflect your understanding and practice of interprofessional supervision?
2. What is missing?
3. What would you like to remove or modify?
4. How does this supervision differ from same-profession supervision?

Following the analysis of the data from phase four the feedback was reviewed by the researcher and integrated to develop the final Map for Interprofessional Supervision (to be discussed in detail in chapter eight).

Ethical Considerations

The University of Auckland Human Participants Ethics Committee (UAHPEC) approval has been obtained for this research (Ref. 014955).

All participants in the research, at each phase, were provided with a Participant Information Sheet (PIS) and a Consent Form (appendices 10 & 11)⁷. The PIS provided brief background

⁷ Rather than append a Participant Information Sheet and Consent form from each phase of the research only those from phase two are included as they are representative of the general layout and content. Where there are exceptions to this standard format specific examples will be appended.

information regarding the research, outlined the measures taken to ensure confidentiality and reported how the material would be collected, stored, accessed and presented. The Consent Forms detailed the participants' rights and responsibilities in the research. In particular it advised that their participation was voluntary, that they had the right to stop the recording at any time and that they could withdraw from the research without any disadvantage to themselves. Because of the sensitivity of the recorded material in phase three a separate consent form was devised for this phase of the research (appendix 12).

The consent form, which was provided to all of the participants via email prior to the interview (a copy was also available at the interview), allowed the participants to select an option to "review the transcript to check the data and to ensure anonymity has been achieved". One of the five phase one participants, fifteen of the phase two participants and three of the phase three dyads availed themselves of the opportunity to review the transcript. The transcribers of the audio recordings were engaged in an official capacity to perform this work and were required to sign a form to ensure the material remained confidential to the research process (appendix 14).

Particular ethical issues within the research design are considered for each of the four phases.

Phase 1: Confidentiality.

Phase one participants were selected to represent the position of different professions rather than to express personal views and accordingly the material shared in the interviews was a matter of public, rather than private, knowledge. Nevertheless the participants' identities were kept anonymous, though the profession that they represented was identified. This issue was raised and clarified with the participants at interview.

Phase 2: Potential conflict of interest.

Some of the participants in phase two were drawn from cohorts of practitioners who had completed a graduate or post graduate supervision qualification at either the University of Auckland or Wintec. The researcher, until 2007, was a senior lecturer on the University of Auckland's graduate diploma of professional supervision. From 2008 until 2014 the researcher, as the Head of School Social Development and later as Centre Director of the Centre for Health and Social Practice at Wintec, held ultimate responsibility for the delivery of the graduate and post graduate qualifications in supervision at that institution. All these programmes draw upon previous research and academic writing of the researcher. Apart

from occasional guest appearances, however, the researcher had not held any teaching or assessment role with regards to any students from 2008 to 2014. In 2015 the researcher held a part time teaching position at the University of Auckland on the post graduate professional supervision programme and from 2016 until the present has been employed as a senior lecturer in a 0.3 FTE position (also see positioning statement chapter one).

The researcher's roles within the education sector and as a researcher in the area of professional supervision are relevant to the current research process as they inform and provide context to her research questions. It was important to ensure that participants were aware of these varied roles. Phase two, however, called for participants who were *graduates* of a supervision programme and so no current students were eligible to be included in this part of the research process.

Phase 3: Sensitivity of content.

Phase three of the research required participants to record live supervision sessions which recorded actual practice situations. Whilst the researcher was interested in the skills, processes and structures employed in interprofessional supervision, it was nevertheless probable that material would be shared in the session regarding a service user or professional colleague. Prior to the recording the participants were alerted to this possibility and they were encouraged to disguise the identity of any person they discussed in supervision. It was recognised that the selected participants in this research were experienced and trained in supervision and from this it was considered that the participants would understand the difference between professional supervision and the activities of case review, case audit and case management where client details, as opposed to supervisee reflections, are more likely to be discussed. It was emphasised that the recording device could be turned off at any time during the session or for intervals during the session. Raw data would only be viewed by the researcher and the transcriber and transcripts would be anonymised. This detail was included in a consent form specifically designed for this phase of the research (appendix 12).

In Aotearoa NZ health and social service delivery is subject to the provisions of the Privacy Act 1993, the Health and Disability Commissioner Act 1994 and individual professionals are accountable to the codes of ethics of their professions where confidentiality is explicit at all levels of the service provision. It is therefore reasonable to expect that the clients who access the services of those supervisees who have volunteered to participate in the research will have been informed of the professional requirement and practice of professional supervision. Client consent was therefore not sought by the researcher.

Participants in phase three were recruited from those who had participated in phase two but acceptance was dependent on the agreement of the phase two participant's partner in supervision (supervisor or supervisee). Care was taken that the partner did not feel pressured or coerced to participate in the research, or feel disadvantaged if they declined to participate. In order to address this, the researcher provided a written invitation to the 'partner'. To ensure confidentiality the letter was given to the phase two research participants to hand on (appendix 13). The invitation expressly invited the 'partner' to contact the researcher should the 'partner' have any questions or concerns. The researcher also offered to meet with the supervision pair prior to the recording if they so wished. No participants availed themselves of this invitation.

Prior to the study it was specified that, if it should transpire that the partner of a participant was a student on the supervision programme where the researcher was currently teaching, the researcher would not participate in any assessment of that student's work. No current students participated in the research.

The participants in phase three, where at least one of the supervision partners was experienced and qualified in supervision, based their supervision on negotiated supervision contracts where confidentiality was addressed. Both supervisor and supervisee were aware of the expectations of the researcher and voluntarily consented to provide a recording of a live supervision session. Responsibility for managing the confidentiality of that supervision session and of the recordings rested with those participants.

Phase four.

No ethical issues were identified for phase four.

Limitations

There are a number of limitations or constraints which pertain to this research. Some of these were known at the beginning of the project and were accepted as necessary constraints of this type of research. The first in this group is that the research is situated in Aotearoa New Zealand where practice within the health, psychological and social service sectors is referenced to, and subject to, distinctive social, legislative and political influences. As such the research is particular to this context and transferability of certain findings to other countries would need to be considered with care.

Second, the research seeks to explore and describe interprofessional supervision. It is not evaluative. Whilst personal subjective comments are, from time to time, offered by or elicited from the participants, the research does not purport to measure the effectiveness or quality of interprofessional supervision. Third, the research is not comparative. Again with the note that from time to time individual opinions were elicited or offered and recorded, the research does not compare or measure interprofessional supervision with other forms of supervision, including same-profession supervision.

Other limitations became evident during the process of the research, several of which stem from the sampling criteria. These include entities and groups of practitioners whose voices were not canvassed and so were not included. To establish the context for interprofessional supervision the views of representatives of regulatory and professional bodies were elicited and relevant legislation and professional codes examined. Missing from this scene-setting are the employers/managers and the employing organisations. Many of those who work in the health, psychology and social service sectors are employed in situations where organisational policy and government funding structures shape supervision practice. Throughout the research, and particularly in phase four, the influence of these organisational policies and the associated management direction on supervision partnerships and choices was evident, but this was not an area which was specifically targeted and explored.

Criteria for inclusion in this research required participants to have knowledge about, and experience of, supervision and to be currently in an interprofessional supervision relationship. The reason for this, as detailed earlier, was to ensure an informed discussion regarding interprofessional supervision. This objective was achieved and the data also showed that all but two of the participants had chosen interprofessional supervision. Again however, particularly through data collected in phase four, it was suggested that many supervisees do not get to choose their supervisor. The research sampling criteria thus effectively excluded an unknown, but potentially large, group of practitioners who have no wish to be engaged in interprofessional supervision or who, with little or no experience or knowledge of supervision, are not in a position to make an informed choice. It is also noted that the professions to which the research participants belonged, as discussed in chapter five, with the exception of nursing and the non-regulated social service sector, are professions where supervision is an established and mandated practice with which professionals are expected to engage for the duration of their career. These commonalities of supervision practice and expectation, while not intentional in the research design, may have thus not reflected the experiences of those employed in the health, psychological and social services

for whom supervision is not common or accepted practice. Also absent from the research are the views of those who, in Aotearoa New Zealand, seek cultural supervision from a supervisor who shares their ethnicity or culture but not their profession. Cultural diversity was raised and explored by the participants as an aspect of the range of difference and diversity to be negotiated in supervision (chapters six and eight) but supervision, where the participants share neither profession nor culture, was not considered.

Consideration of these limitations and constraints sets the scene for future research to seek the voices of these groups of organisations, managers and individual professionals. Several questions can be posed. What influence does supervision training and qualifications have on supervision practice and the choices that professionals make in that regard? What are the experiences of professionals who reluctantly participate in an interprofessional relationship? What are the factors which drive organisational policy to support or not support interprofessional supervision for employees? How is difference of profession managed and negotiated in supervision relationships which are based on culture?

Conclusion

The epistemological (social constructionist) underpinnings of this research reflect a basic premise of interprofessional supervision which is that there are multiple truths which need to be noted, valued and negotiated for meaning when engaged in supervision of this nature. The sequential research design of the study supports this understanding by providing a staged process through which expert informants are invited to build and contribute to the co-creation of a map of interprofessional supervision. The following chapter, chapter five, sets the scene for this co-creation by identifying the legislative, regulatory and professional mandates and expectations of supervision for the key five professions represented in this study.

Chapter 5: Supervision in Aotearoa New Zealand - a context

“The area of supervision encompasses numerous approaches, models, and views, so that we cannot talk about supervision as something uniform” (Vec, Rupnik Vec, & Žorga, 2014, p. 103).

This lack of uniformity, discussed in chapter two, when combined with the parameters drawn by legislation, the application of different professional codes, discipline knowledge, scopes of practice and associated nuances of language, creates added complexity when exploring interprofessional supervision. Despite this, and in seeming contradiction, when considering supervision as an aspect of professional practice, many professions are seen to ascribe similar principles and values to supervision and to hold similar expectations of their professional practitioners.

Within a mix of similarity and difference, prescription and choice, interprofessional supervision occurs. In order to begin to understand how this supervision is managed in the actual face-to-face interprofessional encounter, it is useful to consider what expectations and understandings are brought to supervision from broad legislative and professional governance perspectives. Chapter five focuses on the context of supervision in Aotearoa New Zealand for the five professions included in this study: counselling, occupational therapy, psychology, nursing and social work. The chapter is divided into two parts.

Part one identifies the legislation which shapes the mandate for health, psychological and social service delivery. Within this framework the regulatory and professional body codes of practice, competencies, expectations and requirements for supervision of the five professions are examined. Part two explores material gathered from semi-structured interviews conducted with representatives of the five professions. The ways in which these representatives of the regulatory and/or professional bodies interpret the legislation, understand their profession’s requirements of supervision and how these are presented in practice are considered. Because of similarities in the approach to supervision taken by occupational therapy, psychology, social work and counselling, these four professions are considered together. The material presented is organised according to four themes, which were constructed from analysis of the data from the interviews with these representatives: attitudes to interprofessional supervision; developmental readiness for interprofessional supervision; factors which may shape a choice for interprofessional supervision; quality

supervision and professional boundaries. The interview with the nursing profession is considered separately.

The five professions were chosen, (purposely selected (Creswell, 2013) as identified in chapter four), for two reasons. First, they represent a range of regulatory status. Registration of these professions is variously mandatory, voluntary or not available. Second, they represent professions which have featured in previous studies of interprofessional supervision (Beddoe & Howard, 2012; Berger & Mizrahi, 2001; Crocket, Cahill, et al., 2009; Hutchings et al., 2014; Townend, 2005). With one exception, the five professions examined align with the professional affiliations of the 29 participants who were interviewed in phase two of this research (see chapter six). The exception is one supervisee who was employed in the non-regulated workforce. The professions will be considered here in turn, ordered according to their regulatory status.

Legislation

As recognised in chapter two, the impact of neo-liberal ideology on the practice environment of health, psychological and social services internationally and in Aotearoa New Zealand has been far reaching and, in its turn, professional supervision has been affected (Beddoe, 2016; O'Donoghue & Tsui, 2012). In this regulatory environment where efficiency, accountability and targeted outcomes shape service delivery, in Aotearoa New Zealand two pieces of legislation were passed which in turn shaped the codes and policy of health, psychological and social service professions: The HPCA Act (2003) and SWR Act (2003). Covering a number of health professions, the HPCA Act (2003), whilst influencing service delivery and professional accountability in all of the health professions, has had varied impact on professional supervision and the professions have been differently positioned to respond. The SWR Act (2003), introduced in the same year, has exerted similar influence on social work practice and service delivery, but unlike their professional health colleagues, for social workers registration has not been mandatory⁸. Accountability for social workers to maintain practice standards and competencies has thus been less unified and may be shared between the SWRB and the professional social work association, ANZASW. Because neither registration nor membership of the professional body has been mandatory, at the present time it is possible that some social workers are accountable to neither body.

⁸ On 27 February 2019, the Social Workers Registration Legislation Act 2019 (SWRL Act) was passed. Under the provisions of this Act as of 27 February 2021 the registration of social workers will be mandatory (Social Workers Registration Legislation Act 2019, section 6). For the purposes of this research however the registration of social workers will be considered as voluntary, in line with the legislation which was current at the time of the research.

Health Practitioners Competence Assurance Act 2003.

The principal purpose of the HPCA Act “is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions” (2003, p. 13). To practice under the Act health practitioners are required to be registered in a scope of practice and health regulatory authorities were appointed and charged with the responsibility to manage this registration and to ensure that the purpose of the Act was effected. Of the professions considered in this research, three (occupational therapy, psychology and nursing) are subject to the requirements of the HPCA Act and subject to the regulatory governance of their respective authority: OTBNZ, NZPB and NZNC.

The HPCA Act (2003, p. 98 section 115) provides for individual regulatory authorities to determine and “to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession”. Thus, each profession has the ability to determine the status and expectations of (professional) supervision within that framework of standards of competence (clinical and cultural) and ethical practice. The Act however is not entirely silent on the matter of supervision but requires practitioners who have a condition (a restriction or limit) (HPCA, 2003, p. 17) imposed on their scope of practice to practice under supervision. The following definition of supervision is provided: “supervision means the monitoring of, and reporting on, the performance of a health practitioner by a professional peer” (HPCA, 2003, p. 18). Such statement has little connection to the breadth of definition which has become accepted for professional supervision practice by most professions. The Act further defines *professional peer* “in relation to a health practitioner, [as] a person who is registered with the same authority with which the health practitioner is registered” (HPCA, 2003, p. 18). As such this prescribes that supervision in these situations is conducted by a person from the same profession.

The provisions of the HPCA Act (2003), in respect to those who have a condition on their scope of practice, are broad and focus on the supervision of those whose fitness or competence to practice is under scrutiny because there has been a complaint, or concern has been expressed about a particular practice. Other conditions on scope of practice, and thus also requiring supervision under the Act, may be imposed through individual regulatory authority policy. Here, conditions typically apply to situations where the practitioner is new to practice in the profession, new to practice in Aotearoa NZ or has returned to practice after an absence.

Outside of these requirements, each regulatory authority has the autonomy to define and structure the arrangement of supervision according to its own professional standards and expectations. Supervision is commonly, but not always, considered to be a component of continuing competence. Each of the three professions in this research, which are subject to the HPCA Act (2003), will be considered in turn.

Occupational Therapy

With reference to the supervision requirements of occupational therapists the OTBNZ (2016) makes the following statement:

The Registrar of the OTBNZ is responsible for ensuring that practising occupational therapists meet the required standard of competence, with reference to the Competencies for Registration and Continuing Practice, and Code of Ethics. Supervision is a critical component of continuing competence, and is therefore incorporated into the practice of all occupational therapists. (p. 2)

They continue: “all registered occupational therapists with a current license to practice are required to actively engage in professional supervision. The frequency and mode of supervision may vary according to individual circumstances and practice context” (OTBNZ, 2016, p. 3). Citing obligations under the Code of Ethics for Occupational Therapists (Principle 1.3.8), the Competencies for Registration and Continuing Practice and the ePortfolio (OTBNZ recertification programme), the OTBNZ (2016, p. 3) evidences the specifics of this requirement to engage in supervision practice.

A suitable supervisor is identified by the OTBNZ code of ethics (2015) as “a person who has sufficient self-awareness, interpersonal competence, and knowledge of processes relevant to the area of practice of the supervisee to facilitate that person’s professional development” (p. 9). Occupational therapists are strongly recommended to undertake training before becoming a supervisor and supervisees are encouraged to seek supervision from someone who has such training and who has “capacity to foster critical reflections, challenge and support growth in practice” (OTBNZ, 2016, p. 5). The board expresses a preference for supervision to be conducted with an occupational therapist who is trained in supervision but accepts that there may be situations when a supervisor from another health profession may be appropriate (OTBNZ, 2016, p. 5).

Three standard registration circumstances are identified which require supervision for condition on scope of practice: new graduate, return to practice in New Zealand and overseas qualified registrant. “Practitioners with a condition on their scope of practice” they say “must

receive supervision carried out by a registered occupational therapist with a current license to practice, and no condition on his/her own scope of practice” (OTBNZ, 2016, p. 7). Finally, the board identifies occasions where the condition of supervision is imposed due to “an order of the Health Practitioners Disciplinary Tribunal, a competence, conduct or health issue” (OTBNZ, 2016, p. 7). The board is careful to distinguish this form of supervision from professional supervision and recommends that the practitioner access both forms of supervision contemporaneously.

Psychology

In a similar way to the occupational therapists, the NZPB identifies its obligation to the public, under the HPCA Act 2003, to ensure that every psychologist is maintaining his or her competence, and names supervision “... as a key mechanism to achieve this. Supervision is underpinned by reflective practice as a core competency, that is, one of the foundation competencies which all psychologists are required to have” (NZPB, 2017, p. 1).

The NZPB’s Guidelines on supervision (2017) further detail the Board’s expectations of the supervision arrangements for psychologists. Regardless of experience or work context, practicing psychologists are expected to engage in supervision throughout the duration of their career. The Board, recognising that supervision needs will change over time and from one context to another, is accommodating of a variety of supervision arrangements. With certain provisos this includes supervision arrangements where the supervisor is from another profession:

In some situations it may be appropriate for psychologists to have supervision with a person who is not a psychologist. For example in rural areas there may be more restricted choice or there may be a professional from another discipline who offers specialty skills of interest to the supervisee. However this person should be registered or affiliated with a recognised professional body. (NZPB, 2017, p. 7)

Psychologists are tasked with making their own supervision arrangements which includes choosing their supervisor. The standard frequency for supervision for a full time psychologist is two hours per month, but this will vary according to factors such as experience, task and context. The role of supervisor meanwhile is “regarded as a core part of a psychologist’s work” (NZPB, 2017, p. 3). A psychologist, it is assumed, will provide supervision at some point in his or her career. It is expected that psychologist supervisors:

have attended (or be planning to attend) at least one entry level supervision course recognised/accredited by psychology professional bodies such as The New Zealand Psychological Society (NZPsS) and the New Zealand College of Clinical

Psychologists (NZCCP) or other recognised training providers and be conversant with current supervision theory, practice, and research. (NZPB, 2017, p. 6)

Of particular relevance to this research is the acceptance of, and mandate for, psychologists to provide interprofessional supervision. “Psychologists may also provide supervision for practitioners in other professions” (NZPB, 2017, p. 3).

The guidelines on supervision note that different meanings of supervision are in use in the workplace and psychologists are adjured to remain true to the definition of supervision and practice standards presented by the Psychology Board:

Supervision is defined as a scheduled time to meet with a respected professional colleague for the purpose of conducting a self-reflective review of practice, to discuss professional issues and to receive feedback on all elements of practice, with the objectives of ensuring quality of service, improving practice and managing stress. A distinction is drawn between the term “clinical supervision” as used within the psychology profession and the way some other stakeholder groups use the term “supervision”; for example employers may use the term to refer to line management monitoring. (NZPB, 2017, p. 2)

The definition of supervision provided by the HPCA Act (2003) is noted, (“the monitoring of, and reporting on, the performance of a health practitioner by a professional peer” (HPCA, 2003, p. 18)) but psychologists are steered towards an alternative term, *oversight*. Defined in the Act as “professional support and assistance provided to a health practitioner by a professional peer for the purposes of professional development” (HPCA 2003, p. 17), *oversight* is considered to more “closely [reflect] supervision as it is routinely practised within [psychology], and as it is used in [the Psychology Board] guidelines (NZPB, 2017, p. 2).

Nursing

The NCNZ, established under the HPCA Act (2003) in the same manner as the occupational therapy and psychology boards, is similarly charged to set and maintain competence and standards of practice, in this instance nursing practice, in order to protect the public. In contrast to the other two professional boards, which name supervision as a *critical component* (OTBNZ, 2016) or *key mechanism* (NZPB, 2017) in the maintenance of professional competence, the NCNZ portrays supervision as a vehicle by which competence is developed, monitored and repaired, but not maintained. Developmentally, “the nursing student is expected to be supervised in practice by a registered nurse when the competencies relate directly to an undergraduate nursing student” (NCNZ, 2012, p 7).

Supervision, however, plays a central role in the NCNZ review process, a process which is initiated when the competence of a registered nurse is under scrutiny. The nurse in question is placed under the supervision of a senior registered nurse whose role includes reporting back to the council with regard to the nurse's practice. The supervision may be direct, "this means another registered nurse must be working alongside the nurse supervising his or her practice at all times" or indirect, where "the supervisor works in the same facility or organisation as the supervised person but does not constantly observe their activities" (NCNZ, 2015, p. 7). The expectation that the supervising registered nurse monitors, assesses and reports to the NCNZ with regard to the competence of the nurse in question is closely aligned to the definition of supervision provided in the HPCA Act (2003, p 18). Supervision is thus a process aimed to repair or monitor a deficit rather than a process of reflection to promote critical self-awareness, ongoing professional development and thus maintain competence.

An exception to this understanding of supervision is found in the competencies outlined for nurse practitioners (expert nurses who work within a specific area of practice incorporating advanced knowledge and skills). Competency 1.4 (NCNZ, 2017) states that the nurse practitioner "self-monitors and critically reflects on practice including through regular professional supervision, collaborative case review and audit of practice, including prescribing" (p. 2). No definition, however, is provided to explicate what is meant by 'regular professional supervision' and there is no indication of the required frequency of such supervision or of any expectations of expertise or training for supervisors.

In summary, and reflective of the views of supervision which are held by nurses as reported in chapter two, supervision with the aim to monitor and assess is available to student nurses and required for registered nurses whose competence is under review. The NCNZ's competencies for registered nurses (NCNZ, 2012) include reflection, consultation, debriefing and monitoring the quality of work as a means through which registered nurses can maintain the safety of patients. However, with the exception of nurse practitioners, supervision is not identified as a way to focus these activities. Professional supervision is expected of nurse practitioners but no definition or elaboration is provided to clarify this term.

Notwithstanding the position taken by NCNZ, the New Zealand Nurses Organisation (NZNO) commonly referred to as the nurses' union, provides a six page fact sheet on supervision which details such things as the purpose, definitions, benefits, requirements for effective supervision and outcomes for supervision. A definition of supervision is presented which describes supervision "as a forum for reflection and learning" (Davys & Beddoe,

2010, cited in NZNO, 2015, p. 1). It is noted that the breadth of this definition is intended “to capture the fundamental essence of supervision regardless of whether it is undertaken as professional or clinical supervision” (NZNO, 2015, p. 1).

The ‘requirements for effective supervision’ cite the need for organisational support and funding, and clear policies and procedures that outline the type of supervision offered (which may be multiple types), where and when it should take place, and who should take part (NZNO, 2015, p. 3) but are not accompanied by any detail. Once these requirements are in place the fact sheet lists organisational and individual parameters which are designed to ensure that the supervision is effective. These parameters include, among other things, the need for a process of implementation and evaluation of supervision, for supervisors to have “undergone a prescribed course in supervision” (NZNO, 2015, p. 3) and for nurses and midwives to be able to choose a qualified supervisor. A section titled “engagement between supervisor and supervisee” (NZNO, 2015, p. 4) notes the importance of a supervision contract and the need for confidentiality. Despite the breadth of these lists the document is short on specifics. It does not identify such things as what should be included in a supervision policy, the frequency of supervision, what constitutes ‘a prescribed course in supervision’ and is silent on whether it is acceptable for nurses to be supervised by someone from another profession. The document concludes with a strong endorsement of supervision but no statement that it is, or should be, a requirement of nursing practice:

Supervision is an important component of nurses’ and midwives’ professional development and supports nurses and midwives to ensure quality patient services. Supervision has benefits and outcomes for the individual nurse, patient and the employer. NZNO supports access to and availability of supervision in all areas of nursing and midwifery practice. (NZNO, 2015, p. 4)

NZNO however incorporates within its structure sections and colleges which are ‘groups of members focused on a specific field of nursing’. NZNO members are able to ‘join up to three sections or colleges which relate to [their] practice’ (NZNO, 2019). Te Ao Māramatanga New Zealand College of Mental Health Nurses is one of these colleges. Mental Health Nursing is described as “a specialised branch of nursing practice that builds on the competencies expected of all nurses who practice in Aotearoa, New Zealand” (Te Ao Māramatanga, 2012a, pp. 10–11). Mental health and addictions nurses, registered by NCNZ under the same competencies as all registered nurses, are identified as practising ‘in the specialty of mental health’ (Te Ao Māramatanga, 2012a). Membership of Te Ao

Māramatanga New Zealand College of Mental Health Nurses is voluntary. Of the seven nurse participants in this study, one identified as a registered mental health nurse.

Six standards of practice apply to mental health nurses practising in mental health and addiction services, regardless of the setting (Te Ao Māramatanga, 2012a, p. iv). The fifth of these standards details the clear expectation that mental health and addiction nurses will receive supervision (Te Ao Māramatanga, 2012a, p. 10). Specifically, standard five states “The Mental Health Nurse is committed to their own professional development and to the development of the profession of Mental Health Nursing” (Te Ao Māramatanga, 2012a, p. 10). Under this standard the mental health nurse is expected to “demonstrate an understanding of models of professional supervision, reflective practice and peer review”, to “engage in professional supervision and reflective practice” and to value “the place of professional supervision in professional development” (Te Ao Māramatanga, 2012a, pp. 10–11).

Te Ao Māramatanga New Zealand College of Mental Health Nurses supports its commitment to supervision with additional supervision guidelines. Of interest here is the replacement of the term supervision with the term Practice Development Support. The following explanation is provided. “The identified language preferred by primary care nurses for this relationship between mental health and primary care nurses is Practice Development Support.” Practice Development Support is described to:

...[assist] the primary care nurse with translation of knowledge and skills into practice. Reflective practice is the foundation for the relationship between nurse and supervisor providing support, with the overarching goal of enhancing confidence and practice in the primary care setting. (Te Ao Māramatanga, 2012b, p. 1)

Notwithstanding this alternative name, within the document the participants continue to be described as supervisor and supervisee.

The guidelines recommend that supervision (practice development support) occur as frequently as required by the nurse, but at no less than monthly intervals. Arranging supervision and participation in supervision are the responsibility of the nurse and supervisors are expected to be trained and competent as supervisors and to be engaged in supervision themselves. As with the other professions discussed there is a preference for nurses to be supervised from within the profession, but exceptions are tolerated. General guideline 5, *selection of a supervisor* states:

Nurses ideally supervise nurses. This facilitates the use of theoretical and ethical frameworks from nursing, thus promoting good nursing practice. However, nurses from time to time may choose to be supervised by other professionals because of particular development needs or resource issues. (Te Ao Māramatanga, 2012b, p. 2)

Mental Health nurses are further referred to detailed and comprehensive guidelines for supervision which have been prepared and published by Te Pou o te Whakaaro Nui “a national centre of evidence based workforce development for the mental health, addiction and disability sectors in New Zealand” (Te Pou o te Whakaaro Nui, 2019).

Throughout these discussions and guidelines on supervision (NZNO, Te Ao Māramatanga and Te Pou o te Whakaaro Nui) is an interesting commentary which sets a distinction between *professional* and *clinical* supervision. Citing the Care Quality Commission (2013), NZNO considers professional supervision as:

a process that does not necessarily involve reflection on clinical practice but on professional behaviour, interactions with others and outcomes, keeping up with developments in the profession, identifying professional training and continuing development needs, and ensuring the practitioner is working within professional codes of conduct and boundaries. (NZNO, 2015, p. 1)

Clinical supervision by contrast:

is primarily focused on learning to develop and improve practice and ensuring safe practice (Cassedy, 2010). Clinical supervision also provides an opportunity to discuss individual cases in depth (Care Quality Commission, 2013). It may also involve assessment by the supervisor of the supervisee. (NZNO, 2015, p. 1)

Te Pou o Te Whakaaro Nui (2015) makes a similar differentiation between professional supervision and clinical supervision. The former, they say is between a supervisor and a supervisee from the same profession:

... professional supervision is with a supervisor from the same profession as the supervisee, and therefore has a focus on development of the supervisee within their chosen profession; hence the use of the term professional. (Te Pou o Te Whakaaro Nui, 2015, p. 7)

Clinical supervision, however:

may refer to the type of supervision that can be offered across professions or disciplines (trans-professional) because it has a focus on clinical practice in a particular role or in a particular area (for example mental health and addiction) rather than within a profession. (Te Pou o Te Whakaaro Nui, 2015, p. 7)

In a recent update of their publication (Te Pou o Te Whakaaro Nui, 2017) the interchangeability of the terms professional and clinical, in practice and in the literature, is noted along with the potential for confusion about their application to supervision (p. 11). Asserting that the original position on these terms has been held (Te Pou o Te Whakaaro Nui, 2017, p. 11) a revised set of definitions is offered. These new and simpler definitions, however, particularly when considered alongside the NZNO (2015) position, do not add clarity to the general question of who is considered to be a suitable and acceptable supervisor for a registered nurse. Does a nurse require same-profession supervision for clinical practice, where according to NZNO (2015) in-depth clinical practice and matters of clinical safety are discussed (and where assessment may occur) or for professional practice, where broader features of the work of the profession are a focus? These updated definitions are offered:

- Clinical supervision is a term used to describe supervision focused on the supervisee's clinical practices.
- Professional supervision is a more inclusive term describing a practice that incorporates all aspects of a supervisee's role – clinical, academic, management and leadership. (Te Pou o Te Whakaaro Nui, 2017, p. 11)

Social Work

Social Workers Registration Act 2003 and Social Workers Registration Legislation Act 2019.

On 27 February 2019, as noted in footnote 8, the Social Workers Registration Legislation Act was passed. This Act amends the provisions of the SWR Act 2003 and introduces, among other things, mandatory registration for social workers as from 27 February 2021. The amended Act however does not affect this present discussion of supervision for social workers and accordingly the following discussion will refer to the SWR Act 2003 which was the legislation in operation during the period of this research.

As is the case with the HPCA Act 2003, the primary purpose of the SWR Act 2003 is to protect the safety of members of the public, by prescribing or providing mechanisms to ensure that social workers are: Section 3 (i) competent to practise; and (ii) accountable for the way in which they practise" (SWR, 2003, p. 7).

Within the SWR Act (2003) supervision is referred to on two occasions. Both these references consider situations where questions or concerns have been raised about the professional competence of a social worker. The first occasion states that supervision can be included as a general condition of a practicing certificate when: a social worker's registration

has been suspended, when the social worker has not completed a competence assessment in the last 5 years or when the social worker has no current practicing certificate because the registrar of the SWRB has refused to issue one (p. 17). The second occasion refers to situations when supervision is included as “a stated restriction[s] (as to employment, supervision, or otherwise)” (SWR Act, 2003, Section 83 (1) (a) ii, p. 45) or when a complaint has been upheld with regards to the conduct of a registered social worker. The SWR Act does not provide any definition of supervision, but from the context in which supervision is employed, monitoring, oversight and reporting are inferred.

Social Workers Registration Board.

The SWRB, in a similar manner to OTBNZ, NZPB and NZNC, was established as the regulatory authority under the SWR Act (2003) to manage and administer the registration of social workers:

The SWRB’s primary function is to protect the safety of members of the public by prescribing or providing mechanisms to ensure that social workers are competent and fit to practice and accountable for the way in which they practise. A further purpose is to enhance the professionalism of social workers. (SWRB, 2019)

Supervision is clearly identified as a component of competent practice by the SWRB. Under standard 10, which adjures the registered social worker to represent “the social work profession with integrity and professionalism”, registered social workers are required to actively participate “in supervision, continual professional development and career-long learning” (SWRB, 2015a, Core competence standards). The SWRB also provides a comprehensive policy document which introduces supervision as “an essential element ensuring competent social work practice” and which details the expectations of the board in this area. Registered social workers will, Section 4 of the supervision policy states, “access regular professional social work supervision” (SWRB, 2015b, p. 2). Supervision must be appropriate and take place at least monthly. The link between supervision and public safety is explicit:

It is the direct practice, guidance and reflection provided by supervision that enhances professional development and supports competent, accountable and safe practice. Furthermore the Board considers that the interests of the public are best served by the profession requiring all registered social workers to be in a formal supervision relationship. (SWRB, 2015b, p. 2)

The SWRB, however, stops short of defining supervision. It acknowledges the range of definitions accepted, and in use, within the profession and identifies a “high level of consensus within the social work profession and amongst other key stakeholders of the purpose of supervision” (SWRB, 2015b, p. 2). It is nevertheless noted that throughout the supervision documentation the Board variously employs the terms *supervision*, *professional supervision*, *social work supervision* and *professional social work supervision*. The Board *prefers* (emphasis added) (SWRB, 2015b, p. 4) that social workers are supervised by a registered social worker who has completed a professional supervision training programme, but recognises that this may not be possible or appropriate for all social workers. Supervisors who are not social workers are required to provide evidence that the supervision provided meets the “Code of Conduct of the Board and also the generally accepted standards reflected in the Profession’s Code of Ethics” (SWRB, 2015b, p. 4).

Aotearoa New Zealand Association of Social Work.

As registration is not currently mandatory for social workers in Aotearoa New Zealand (see footnote 8), not every practicing social worker is subject to the SWRB supervision requirements. The professional body, ANZASW, membership of which is also voluntary, provides parallel and largely complementary guidelines and policy on what is termed social work supervision. ANZASW (2015) presents the following definition of social work supervision:

a process in which the supervisor; enables, guides and facilitates the social worker(s) in meeting certain organisational, professional and personal objectives. These objectives are: professional competence, accountable & safe practice, continuing professional development, education and support. (Clause 3, p. 1)

In the ANZASW supervision policy document the importance of supervision is established, as is the alignment of supervision with the social work profession. In a strongly worded statement “all practising ANZASW members *are required* [emphasis added] to be receiving core social work supervision with a supervisor who meets the criteria set out in clause 10” (ANZASW, 2015, p. 2). Core Social Work Supervision is specified as “that element of supervision that ensures the worker’s practice demonstrates a commitment to the social work profession together with the ANZASW Standards of Practice and Code of Ethics and the international standards of IFSW” (ANZASW, 2015, p. 2).

Guidelines for frequency of supervision are identified and vary according to circumstance and experience. New-to-practice social workers are required to access one hour per week of

core social work supervision, a frequency which can reduce to one hour per month when they have gained experience. The requirements of the social work supervisor are enumerated in Clause 10 (ANZASW, 2015, p. 3) and despite noting that, “when the supervisor is not a social worker but is a member of a regulated profession they must hold a current APC”, these requirements strongly endorse same-profession supervision:

(10.5) Unless there is *very good reason not to* [emphasis added], it is expected that supervisors will:

10.5.1 Be currently receiving supervision from a social worker;

10.5.2 Have at least two years supervised practice as a social worker;

10.5.3 Be a full member of ANZASW with a current competency certificate.

(ANZASW, 2015, p. 3)

Clause 10 concludes by requiring social work supervisors to “have completed training in social work supervision and hold a recognised qualification in supervision” (ANZASW, 2015, p. 4).

When the supervisor is not a social worker Clause 11 requires the social worker to “describe the very good reason for accessing non-social work supervision” (11.1.1.) and to “demonstrate how they maintain their: professional identity as a social worker (11.1.2.1.) and links with the social work community” (11.1.2.2.) (ANZASW, 2015, p. 4).

In short, social workers are required to engage in supervision by both the professional body and the registration authority. Definitions of Social Work supervision and core social work supervision, provided by the professional body, clearly emphasise the importance of the relationship between supervision and the social work profession. It is preferred (SWRB), and required (unless there is a very good reason) (ANZASW), that the supervisor is a social worker, but exceptions to this are possible.

Counselling

Counselling, the fifth profession considered in this section, has neither statutory regulation nor state registration and as such is self-governing. Professional standards and competencies are determined and maintained through the professional body, New Zealand Association of Counsellors (NZAC).

In October 2017, following consultation with its membership, NZAC launched a new enhanced self-regulatory process which will come into effect in 2019. Preferring not to register under the HPCA act, the membership of NZAC voted in favour of adopting a new

process of self-regulation. “The new self-regulatory process has three components - a more rigorous CPD programme - new training and education standards for new entrants into the profession - a rigorous and robust Code of Ethics” (NZAC, 2017, p. 4). Counsellors who meet the requirements of this new regulatory process will be known as “Counsellors registered with NZAC” (NZAC, 2017, p. 6). Whilst this new development is noted, it is not yet operative. The policies and standards referred to in the following section are thus those relevant to the time period of the research.

New Zealand Association of Counsellors NZAC/Te Roopu Kaiwhiriwhiri o Aotearoa.

NZAC is described on its website as “the national professional association that acts for and with counsellors to monitor and improve the service they provide” (NZAC, 2019, para. 1).

Within the detailed conditions of membership of the professional body (NZAC) supervision features prominently. All practicing counsellors are required to “seek supervision” and supervision is said to support “accountability to clients, employers, the public and the Association” (NZAC, 2015, 1.1). Professional supervision is considered to be “a primary resource for every counsellor in the maintenance and development of safe, ethical and effective practice” (NZAC, 2015, 1.2).

The expectations of supervision vary according to membership status. Those wishing for provisional membership and those wishing to maintain their full membership must have a supervisor who “is a current, full member of NZAC or a similar professional body with a Code of Ethics who requires supervision of their members” and who has “been a member of that body for at least three years” (NZAC, 2015, 1.3 & 1.5). Interprofessional supervision relationships are thus endorsed. Those seeking provisional membership must have been in supervision with their supervisor for at least 12 months. The requirements of those counsellors who wish to move from Provisional to Member status are the same as for their provisional membership, with the exception that there is no longer an interprofessional option, their supervisor must be a full member of NZAC.

Supervisors are expected to be experienced in supervision, to have had supervision training, to be able to articulate their supervision practice and to be engaged in their own supervision. In addition, it is clearly stated that the supervisor “should not be in a position of authority over the counsellor” (NZAC, 2015, 1.7). The purpose of professional supervision is identified as a place for counsellors:

to reflect on and develop effective and ethical practice. It also has a monitoring purpose with regard to counsellors' work. Supervision includes personal support, mentoring professional identity development and reflection upon the relationships between persons, theories, practices, work contexts and cultural perspectives. (NZAC, 2015, 4.1)

Counsellors are required to access regular supervision with the same supervisor over a period of time. There is a recommendation of one hour of supervision per fortnight for a full time counsellor but the frequency may vary according to workload, experience, and personal and professional context. Supervision, it is stipulated, is required not only for counsellors who are seeing clients, but also for any counsellor who is providing supervision.

Despite the absence of statutory or regulatory ordinance, the supervision requirements for counsellors who are members of NZAC, share much in common with the other regulated professions discussed above. It is also noted that counsellors, like social workers, do not have to belong to the professional (or regulatory) body in order to practice.

Table 5.1 summarises the requirements and expectations of the five different professions.

Table 5.1. Requirements and Expectations of Supervision for Five Professions

	Counselling	Nursing	Mental Health Nursing	Occupational Therapy	Psychology	Social Work
Regulatory body	Self-regulation New Zealand Association of Counsellors (NZAC) from 2019	Nursing Council of New Zealand (NCNZ)	Nursing Council of New Zealand (NCNZ)	The Occupational Therapy Board of New Zealand (OTBNZ),	New Zealand Psychologists Board (NZPB)	Social Workers Registration Board (SWRB)
Professional body	New Zealand Association of Counsellors (NZAC)	New Zealand Nurses Organisation (union) (NZNO)	New Zealand Nurses Organisation (NZNO) Te Ao Māramatanga New Zealand College of Mental Health Nurses	Occupational Therapy New Zealand -Whakaora Ngangahau Aotearoa	New Zealand Psychological Society (NZPsS) New Zealand College of Clinical Psychologists	Aotearoa New Zealand Association of Social Workers (ANZASW)
Legislation	Nil	HPCA Act 2003	HPCA Act 2003	HPCA Act 2003	HPCA Act 2003	SWR Act 2003 SWRL Act 2019
Registration mandatory	Self-registration 2019	Yes	Yes	Yes	Yes	Yes from February 2021
Regular Supervision mandatory	Yes	No	Yes	Yes	Yes	Yes
Terminology	Supervision Professional supervision	Supervision Peer supervision Formal supervision	Professional supervision Clinical supervision Practice development support	Professional supervision Kaupapa Maori Cultural	Supervision Clinical supervision Cultural supervision	Supervision Professional supervision Social work supervision Core social work supervision Professional social work supervision
Interprofessional supervision for New graduates	Provisional members No	No (Preceptors)	No	No	Not stated. Same-profession preferred	No
Training for supervision	Expectation	No	Expectation	Strongly recommended	Expectation Entry level course recognised by psych profess body or other recognised training provider	Preference –professional supervision training programme (SWRB) Requirement - training in SW supervision and hold recognised qualification in supervision (ANZASW)
Same-profession supervision explicit	Yes or Member of similar body	N/A	Preferred	Preferred	Preferred	Preferred

Discussion

The regulatory and the professional structures identified above describe the mandate and conditions for the professional supervision of five professions in Aotearoa New Zealand. The material considered indicates that there is congruence between the underpinning professional values, ethics, competencies and codes of practice for professional supervision across the four professions of occupational therapy, psychology, social work and counselling. However, when considering the nursing profession, the understanding, and the valuing, of professional (and clinical) supervision varies at different levels of the profession.

The HPCA Act (2003) provides a very traditional and limited definition of supervision which is inexorably aligned with the monitoring and oversight of practitioners whose competence is either developing or is in question. The SWR Act (2003) does not define supervision but considers it in a similar manner to the HPCA Act. The regulatory authorities of occupational therapy, psychology and social work have variously critiqued their respective Act's definition of, or position on, supervision and have provided careful policy guidelines and expectations for their practitioners with regard to supervision. In parallel, the supervision policies of the professional bodies NZAC and ANZASW demonstrate alignment to the values and expectations expressed in the documents of the regulatory authorities.

Importantly in all these policies, the centrality of supervision to competent practice and ongoing professional development is explicit. "Supervision is a critical component of continuing competence" (OTBNZ, 2016, p. 2). Supervision is a "key mechanism" to maintain competence (PBNZ, 2017, p. 1). Supervision is "an essential element ensuring competent social work practice" (SWRB, 2015b, p. 2). The objectives of supervision are: "professional competence, accountable & safe practice, continuing professional development, education and support" (ANZASW, 2015, p. 1). Supervision is "a primary resource for every counsellor in the maintenance and development of safe, ethical and effective practice" (NZAC, 2015, p. 1). The policy alignment of all of these bodies, regulatory and non-regulatory, suggests that, for these professions, there is an accepted baseline of core standards and expectations for supervision which transcends professional boundaries. Further, this baseline can be seen to be independent of legislative direction and rather reflects the shared values and principles which underpin generic ethical professional supervision practice.

NCNZ however does not take an independent position on professional supervision but rather accepts and is guided by the definition of supervision provided in the HPCA (2003).

Professional supervision has not been a tradition of the nursing profession (Dilworth, Higgins, Parker, Kelly, & Turner, 2013) and has been viewed rather as “management interference or criticism” (Bond & Holland, 2010, p. 83). It is therefore possibly not surprising that, although prescribing competencies (such as reflective practice) which are congruent with professional supervision activities, NCNZ chooses not to connect or align these activities with the practice of supervision.

Within these varied mandates for professional supervision, day to day supervision practice for this group of health, psychological and social service professionals occurs, and choices regarding that supervision are made. Although there is a general preference for practitioners to engage in supervision with someone from the same profession, some practitioners choose to engage with a supervisor, or a supervisee, from a different profession.

Representatives: Regulatory and Professional Bodies

In the following section material from interviews conducted with representatives of the five professions of counselling, nursing, occupational therapy, psychology and social work, is reported. As detailed in chapter four (methodology), phase one of this research invited representatives of the respective regulatory and/or professional bodies to an interview, the aim of which was “to understand the professional values, standards and mandates (professional and legislative) which each profession held regarding interprofessional supervision”. It is to be noted that the respondents, whose comments are included here, were interviewed as representatives and it is accepted that their views may or may not perfectly reflect the stance of the board or professional body of which they are a member. The comments nevertheless provide insights which are useful to consider when exploring professional boundaries at the interface of interprofessional supervision.

Because of the congruence of approach to supervision taken by occupational therapy, psychology, social work and counselling, in the following discussion these professions are considered together. They will be referred to collectively as the ‘health, psychological and social service professions’. Because of the different approach to supervision taken by NCNZ, the regulatory authority for nursing, the nursing profession will be presented separately. In making this division it is acknowledged that within the nursing profession, mental health and addictions nurses, who practice under the specialty of mental health, are accountable to supervision policies and competencies which are well aligned with those of the health, psychological and social service professions represented here. Throughout the discussion the respondents will be identified by their profession.

Health, psychological and social service professions (excluding nursing)

The representatives of the health, psychological and social service professions, when interviewed, were asked to consider the place of interprofessional supervision within their respective profession. From these interviews four themes were constructed: attitudes to interprofessional supervision; developmental readiness for interprofessional supervision; factors which may shape a choice for interprofessional supervision; quality supervision and professional boundaries. These four themes are discussed in turn.

Attitudes to interprofessional supervision.

Of the health, psychological and social service professions interviewed, all but counselling documented a preference for their members to be supervised by someone from the same profession. Notwithstanding this official position, interprofessional supervision was known to occur in each profession and the profession representatives described a range of attitudes when supervisees exercised their choice for a supervisor from another profession. Social work took the position that the registered social worker was competent to make his or her own decision:

Yes, we tend to regard the registered social worker as a person who in most instances, unless there are competency issues, is able to make a judgement on who is the most appropriate professional supervisor given the circumstances at the time. (Social Work)

Occupational therapy emphasised the quality of the supervision rather than the profession of the supervisor:

... it doesn't have to be an OT, if the person has got some good training like that they will help ask the right questions of you. (Occupational Therapy)

Interestingly, particularly in view of the endorsement by NZPB for psychologists to provide supervision to other professions (PBNZ, 2017, p. 3), psychology was less enthusiastic about psychologists being supervised by other professions:

Begrudging acceptance [of interprofessional supervision] that in some circumstances 'ok you can have somebody else', but it is certainly not a ringing endorsement that 'hey this may have value'. (Psychology)

Counsellors, subject to different policy in this area, were provided with a choice; to be supervised by a full member of NZAC or to be supervised by someone who was a member of a similar professional body which was approved by the NZAC executive. The criteria on

which this approval is based however was not defined by NZAC and, according to the profession representative, it was the responsibility of individual counsellors to establish if their supervisor was acceptable:

It's up to the person that is applying for the membership to find out whether the person that is going to be signing off their renewal for membership is qualified to do that. If they don't do that then, you know, they could come unstuck. (Counselling)

The profession representative was unable to clearly identify to whom a counsellor should apply to access this information:

Well I would say it would be the secretary of the membership committee but I don't know the answer to that. That's who I imagine it would be. (Counselling)

To choose a supervisor from a different profession is thus possible and accepted (sometimes begrudgingly) for all these professions. However, to engage in interprofessional supervision requires a practitioner to assert a deliberate choice to move outside of the 'preferences' for same-profession supervision.

Developmental readiness for interprofessional supervision.

The health, psychological and social services representatives were in accord, and aligned with their mandates and policies, that new graduates (and those returning to, or new to, practice in Aotearoa New Zealand) should be supervised within the profession. A supervisor who held, and was able to provide, a strong base of professional knowledge was considered to be important for all these practitioners:

So the idea of supervision for the new grads was about supporting them into practice to ensure that that was there. (Occupational Therapy)

I like to see new graduates stay within the profession. There is a fair amount of enculturation and consolidation of skills and competencies that happens within the first couple of years. (Psychology)

At times, more than one form of supervision was required to ensure that the profession specific issues were covered:

They may be receiving supervision from somebody else on the multidisciplinary team, but we would say, we would be very clear to them, that it's about your professional social work issues. So you may need more

than just the psychiatrist or the psychologist or the cultural advisor.
(Social Work)

Interprofessional supervision however was differently viewed when more experienced, competent practitioners were concerned. It was accepted that these practitioners had well developed practice wisdom and their independent choices were accommodated and trusted:

... someone who is in a more senior position or in management type roles will say 'oh well I've got this great social worker who is going to be my supervisor'. (Occupational Therapy)

Notwithstanding the earlier begrudging accommodation of interprofessional supervision, psychology was accepting of the decisions of competent practitioners:

.... I mean if you are a fully competent and well-functioning psychologist and you choose to have it with somebody else [that is acceptable].
(Psychology)

Social work, whilst accepting a social worker's decision to engage in interprofessional supervision, nevertheless called to mind the SWRB requirement that the supervisor, not the supervisee, account to the SWRB for the standard of that supervision:

We also recognise that some senior and experienced or specialist practitioners may not have a supervisory relationship with another social work practitioner and in such cases the board's requirement is that the supervisor is able to evidence that they provide supervision consistent with the code of conduct of the Board and also the general acceptant standard reflected in the profession code of ethics. (Social Work)

Factors which may shape a choice for interprofessional supervision.

Not all interprofessional supervision arrangements were seen as a matter of first choice. The respondents named situations where interprofessional supervision happened as a matter of necessity. These situations occurred in a range of practice contexts. In some instances the major factor was the lack of a suitable and available supervisor from the same profession and at other times it was a reflection of organisational policy:

The people that struggle a bit more are those in the NGO type organisations where they might be the only OT in the organisation and so they are trying to find someone who is a suitable person to promote supervision. (Occupational Therapy)

It may be that there is somebody other than a social worker who has a better understanding of their work context and it may be easier to raise particular issues with. (Social Work)

..and we hear often, particularly from people in DHBs and that sort of thing, where they are assigned a supervisor and it's not working, but there is only the three of them in the place. (Psychology)

Interprofessional supervision in multidisciplinary work contexts was seen as a natural progression of interprofessional work but could also be considered as a potential limitation of good supervision:

but there is increasing talk of working collaboratively between professions ... So I think there will be a natural tendency as more of that becomes just a normal part of practice for supervision to just be generally accepted. (Occupational Therapy)

I think the disadvantages are if it is not properly matched. So there might be some professional imperialism occurring for want of a better word. I think particularly in some of the multidisciplinary teams I think there is a potential for that if there's not a seniority match or some of those sorts of things. (Social Work)

Finally, private clinical practices, when offering interprofessional supervision, were viewed with caution. Commercial competitiveness and expedient compliance were seen to have the potential to lead to tick box accountability at the expense of good supervision:

The quality of what happens in there I would think would be incredibly variable because they are doing it to demonstrate they are [doing supervision] rather than a genuine desire to reflect on practice and a lot of those ones are doing it in big groups ... So I think they are ticking the 'we are having supervision' box. (Occupational Therapy)

Quality supervision and professional boundaries.

It was notable that a knowledge, and appreciation of the value, of supervision underpinned all of the conversations with the representatives from the health, psychological and social services. Respondents agreed that good quality supervision contributed to good practice. It was acknowledged that the quality of supervision varied in practice and that same-profession supervision was no guarantee of excellence. Expertise and training in supervision were considered to be important and, where present could transcend professional differences.

Well once again it's to do with the quality of the supervision, you know, and if the supervisor is able to really help the person understand what

they're doing and what challenges they are up against and how they can negotiate those challenges and their own processes then I think that could be as valuable as a person was from their [profession] but [who] didn't really operate according to a sound supervision model practice. (Counselling)

Supervision by somebody who is not a registered social worker is preferable to just having supervision with a registered social worker because you think you've got to and it's not good supervision. (Social Work)

I do think that the overriding thing though is the supervisor's insight into supervision and how they operate as supervisor. (Occupational Therapy)

The need for there to be a 'right fit' between the supervisor and supervisee was considered to be important, a matter of choice and independent of profession:

Someone who has always worked in a traditional setting is not going to be right, it's about finding the right person. (Occupational Therapy)

In fact there is a statement in there that says psychologists should be allowed to choose their own supervisor because that fit is so important to the process. (Psychology)

The benefits of interprofessional supervision were identified but at times with provisos that the supervisor had knowledge of both the work context and the profession.

I think it can help practitioners to think a bit more laterally around some of their practice. I think it is really important that if you are having interprofessional supervision that there are some sort of match to the role or experience or understanding the work context. I don't think that I can just go and say I want to have a supervision with X or Y who had no understanding of the sort of work context. (Social Work)

I think ...there are limits to the quality of the supervision if the supervisor doesn't have close working knowledge with the context that the person that the supervisee is coming from. (Counselling)

Knowledge of the profession however, was not always seen to guarantee that the competencies and requirements of that profession were known or addressed. From a position of ignorance, it was suggested, someone from outside the profession was more likely to raise and explore these issues:

...if you choose someone outside the profession you need to arm them with some information that they should be able to have an awareness of. So, you

know, what your requirements are under the code of competencies and your professional development. But you are not going to know it off the top of your head and in fact most OTs don't either, but they don't question it. Whereas I think sometimes someone from outside will question it. (Occupational Therapy)

At other times, echoing Page and Wosket's (2015) encouragement for experienced practitioners to move away from the familiar in supervision and consider "the benefits to themselves and their clients provided by a fresh and possibly more challenging perspective on their work" (p. 48), interprofessional supervision was identified as a potential way to challenge, extend and renew practice:

The flip side is there will be other people who have been practising for 20 years who never would dream of asking anyone except for an occupational therapist and who will almost be quite hooked into the fact that 'well if they're not in my field of expertise then how could they provide supervision?' And those are the people that are still very much in a case management discussion. (Occupational Therapy)

But as I said, for the more experienced practitioners, where the supervision is possibly more normative ... with different sorts of issues [interprofessional supervision] may be just as appropriate to have it depending on the context of the work. (Social Work)

In summary, same-profession supervision is the stated preference of the regulatory bodies for registered occupational therapists, psychologists and social workers. The counsellors' professional body accepts supervision from other professionals but with the caveat that the supervisor is approved by the national executive. Attitudes held by these bodies regarding interprofessional supervision, as described by the profession representatives, vary from encouraging (occupational therapy) to accepting (social work) to reluctant (psychology) to cautious (counselling). All the profession representatives offered a critique of the practice of supervision and, notwithstanding the different levels of enthusiasm for interprofessional supervision, there was considerable agreement about the limitations and benefits. The varied availability and quality of supervision was acknowledged and situations were identified where interprofessional supervision was a necessity of practice context. More crucially, it was accepted that interprofessional supervision could and did offer benefits not provided by same-profession supervision for some practitioners, particularly those with practice experience.

Nursing

Unlike the four other professions considered in this research, the nursing profession has no established tradition of professional supervision practice and this lack of engagement is reflected in the place of supervision in the regulatory authority documentation. NCNZ takes its position on supervision from the definition provided in the HPCA (2003) and no independent critique of supervision is offered. *'But we don't have anything because all the work we do falls out of the HPCA Act that legislation. So there is nothing in there that means we have to do anything around supervision'* (Nursing). Supervision, as recorded in NCNZ documentation for registered nurses, is an activity provided to students, new graduates and those whose competency is in question or under review. It is about monitoring, assessing and ensuring standards are met. Confusingly, and in seeming contradiction however, one of the competencies identified by NCNZ for nurse practitioners is that they participate in 'regular formal supervision', but no definition is offered to illuminate what is meant by this activity and how it relates to the other supervision described.

At this level of regulatory mandate, where supervision as a professional activity aimed at learning, development and support, is neither defined or recognised, there is little context for discussion of interprofessional supervision. As described earlier however, the nurse's union NZNO provides comprehensive supervision guidelines for supervision but stops short of mandating supervision in practice and is silent on the matter of interprofessional supervision. Te Ao Māramatanga New Zealand College of Mental Health Nurses, one of the colleges within NZNO, advances this position and provides detailed expectations and requirements for mental health and addictions nurses. Supervision within the broad profession of nursing is thus presented as a professional activity required only for those in a specific fields of practice.

A context for supervision in nursing.

Nevertheless, nurses who work in areas other than mental health and addiction do engage in supervision. While it is not the intent here to examine the historical development of supervision within nursing, the profession representative provided some context which is a useful place from which to begin to understand the range of attitude and approach to supervision within that profession. Essentially, engagement with supervision within nursing in Aotearoa New Zealand, as described by the profession representative, is largely dependent on the context of employment.

Supervision within nursing as a whole is variable depending where you are employed. So my understanding is it started particularly with mental health nurses because mental health nurses often worked independently and came upon things that were challenging at times. (Nursing)

Independence, or isolation of practice, was the recurring factor cited to indicate the need for, or acceptance of, supervision within the nursing profession. “*When I worked for Plunket we had peer reciprocal supervision recognising that we all worked independently and again out in the community it might not necessarily intercept with nurses*” (Nursing). By way of contrast, nurses in other less isolated contexts, such as in-patient facilities or clinics, were seen to have opportunities for support which were not available to the ‘independent’ nurse.

Yes like if you have to work in a ward you have debriefs and you might have ward meetings. Even if you worked in an aged care facility or GP practice there is that collegial support around you all the time. (Nursing)

This positioning of supervision with activities such as debriefing, ward meetings and collegial support, however, falls short of understanding supervision as a professional activity by which to promote reflection, professional development and competence. It was also noted by the profession representative that the cost of supervision for a large work force such as nursing was considerable and this provided some rationale for the manner in which supervision was provided.

I’m not sure what supervision people have in mental health whether they have peer support supervision or whether they have somebody employed to offer that because it is a cost and you know like if you had the whole work force and they all had to attend supervision ideally that is quite a cost. (Nursing)

In this environment of practice, supervision as a professional activity for nurses is seen to be variously understood, selectively accessed and marginally supported. It is suggested that those nurses who do wish to access professional supervision, be it same-profession supervision or interprofessional supervision, require a clear and strong focus to achieve their objective.

Conclusion

Against this backdrop of legislation, regulation and policy and, despite the preference by the health, psychological and social service professions for same-profession supervision and despite the lack of recognition of supervision as a professional activity by the nursing

regulatory body, interprofessional supervision encounters do occur in the day to day practice of supervision.

It is evident that in some practice contexts policy and resource limitations direct practitioners to interprofessional supervision as a forced choice. It is also evident that interprofessional supervision, although it may be accepted, is not generally promoted by regulatory or professional bodies. Despite this, perspectives shared by the profession representatives have described supervision as a valued professional activity which practitioners, regardless of profession, approach with considered and critical appraisal of their professional needs and of the qualities of the supervisor. In these situations the choice for supervision rests not on the profession of either party but on the personal and knowledge/skill fit between them and on the quality of the supervision practiced.

The next chapter, chapter six, brings the practice of interprofessional supervision into focus and presents the findings of interviews with expert informants who were both knowledgeable and experienced in supervision and who were currently in an interprofessional supervision relationship.

Chapter 6: Interprofessional Supervision: Exploration

I find it so valuable and actually because it gives you the right to challenge as well. You have to actually clarify what you are about, what you're doing, because that other person often views the situation quite differently and it gives you clarity around how I need to approach this to get this outcome. So I find it really valuable I wouldn't swap it. (Olive, OT, R/E)

Chapter six explores the views and experiences of twenty-nine expert informants, supervisors and supervisees, who were qualified and experienced in supervision and were currently engaged in an interprofessional supervision relationship.

The data collected from the interviews, which was as rich in detail as it was broad in scope, was organised to construct three themes.

- Choice and the development of the professional self
- Interprofessional supervision: a structured process
- Diversity as a vehicle for learning

The findings in this chapter are presented around those three themes and subheadings, representing sub-themes which were constructed to supplement those themes, are used to further organise the material. A summary of the benefits and challenges of interprofessional supervision and the qualities needed by those engaged in interprofessional supervision, as identified by the research participants, is included. The chapter concludes with advice, offered by the participants, to anyone considering entering into an interprofessional supervision partnership.

Demographics

The professions or occupations of the expert informants who were interviewed for the study included counselling, nursing, occupational therapy, psychology and social work. One participant was employed in the non-registered social service workforce (Table 6.1). Five participants described belonging to more than one profession and of these two defined their additional profession as “supervisor” and two as “teacher” or “educator”⁹.

Of the 29 people interviewed, 26 currently held roles as both supervisor and supervisee. Four of these participants indicated that both these relationships (as supervisor and supervisee)

⁹ Participants who identified with more than one profession have been grouped with the profession which they named first which, for the purpose of the study, has been considered as their primary profession. When the participants' comments have been included in the findings the separate professional affiliations have been recorded beside the individual contribution.

were with someone from another profession and so both roles met the criteria and were included in the study. The addition of the four participants who responded as both a supervisor and a supervisee brought the total responses to this phase of the research to thirty-three; nineteen supervisors and fourteen supervisees. Apart from one dyad the participants were not engaged together in supervision and described individual and independent supervision experiences.

Table 6.1. Participant Professional Groups Phase Two

Supervisors (n =19)	n	Supervisees (n = 14)	n
Counsellor	4	Counsellor	1
Counsellor/social worker	1	Counsellor/social worker	2
Counsellor/social worker/teacher/supervisor	1	Non-regulated workforce	1
Counsellor/supervisor	1	Nurse	3
Mental Health Nurse	1	Nurse Educator	1
Nurse	1	Occupational therapist	3
Nurse/counsellor	1	Psychologist	1
Occupational Therapist	3	Social Worker	2
Psychologist	4		
Social Worker	2		

The ages of both the supervisors and supervisees ranged between 31 and 70. Although eight supervisors (42%) and six supervisees (43%) were aged between 51 and 60 years, the supervisors were on average older than the supervisees. When considered overall, 14 (73%) of supervisors were aged 51 years or older compared to only seven (50%) of the supervisees. Possibly as a reflection of this age difference, overall the supervisors had also been in practice for more years than the supervisees. Twelve (60%) of supervisors had been in practice for more than 20 years compared to six (43%) of supervisees. A similar but more pronounced distribution was seen in the number of years each group had been involved in interprofessional supervision relationships. Supervisors indicated that they had between one and 30 years of engagement with interprofessional supervision, with seven (37%) having more than 15 years' experience. In contrast, no supervisee reported more than 15 years' experience of interprofessional supervision. The demographics of the participants of phase two are presented in Table 6.2.

Table 6.2. Demographics Phase Two

Demographic	Supervisors (<i>n</i> = 19)		Supervisees (<i>n</i> = 14)	
	<i>n</i>	%	<i>n</i>	%
Age				
31 - 40 years	1	5	2	14
41 - 50 years	4	21	5	36
51 - 60 years	8	42	6	43
61 - 70 years	6	31	1	7
Years of Practice				
5 – 10 years	0	0	3	21
11 - 20 years	7	37	5	36
21 - 30 years	6	32	3	21
31 - 40 years	5	26	3	21
41 - 50 years	1	5	0	0
Years of Interprofessional Supervision				
1 – 5 years	4	21	6	43
6 – 10 years	5	26	5	36
11-15 years	3	16	3	21
16 – 20	5	26		
21-30	2	11		

Ethnically, 14 (74%) of supervisors identified as New Zealand European, Pākehā or European (including one participant who identified as New Zealand European Chinese), three supervisors were British and one was of South African European descent. Only one supervisor identified as New Zealand Pākehā/Māori. The supervisees described similar patterns of ethnicity, ten (71%) identifying as New Zealand European, Pākehā or European, one supervisee was Māori and Pākehā, one was British, one Canadian and one Hungarian. The sample was heavily represented by women with only two men, less than seven percent, responding to the invitation and being included in the research.

Interestingly, a majority of the participants shared a similar range of work contexts: health, tertiary education and/or private practice (see Table 6.3). The exception to this was three supervisees who worked for non-governmental organisations (NGO). Of significance however, is that where only one supervisee (7%) was in private practice (and this was as an adjunct to employment in health), 15 (79%) of supervisors were involved in private practice. Of these supervisors, nine (48%) were also employed in either the health or the tertiary education sectors while the remaining six (31%) operated solely in private practice. This number of supervisors in private practice is possibly illustrative of O'Donoghue's (2004)

observation of the increasing privatisation of supervision where supervision is marketed “as a profession and discipline in its own right” (p. 5).

Table 6.3. Practice Contexts Phase Two

Practice contexts	Supervisor (<i>n</i> = 19)		Supervisee (<i>n</i> = 14)	
	<i>n</i>	%	<i>n</i>	%
Health	4	21	7	50
Health & Private Practice	2	11	1	7
Tertiary Education			3	21
Tertiary Education & Private Practice	7	37		
Private Practice	6	31		
NGO			3	21

When asked what profession their supervisor represented the supervisees identified supervisors from six different professions but there was a clear preference for supervisors who held a counselling qualification. Two of the supervisors were identified as having counselling as their sole profession and four others indicated that they had a counselling qualification in addition to other professional qualifications. Three participants were supervised by a psychotherapist which made psychotherapy the next most common professional affiliation of supervisors.

On the other hand, the supervisors in the study described a diverse group of interprofessional supervision partners. This was possibly a reflection of the number of supervisors who were in private practice and who thus drew supervisees from a broad range of employment contexts. Their supervisees included practitioners from specific professions, a wide range of people employed in some capacity (often non-regulated) in the social or human service sector, and managers from both corporate and social service sectors. For many of the supervisees in these latter groups, supervision was neither mandated nor, at times, recognised as essential to their work. The profession, or professional group, of the participants’ supervision partner is represented in Table 6.4.

Table 6.4. Profession of Supervision Partner Phase Two

<i>Supervisees: Profession or Professional group of supervisor</i>	
Counsellor	Nurse
Counsellor /Corporate Manager	Nurse/Human Resource Manager
Counsellor/Minister (Religion)	Physiotherapist
Counsellor/Nurse	Psychotherapist
Counsellor/Psychotherapist/Nurse	Social Worker
Educational Psychologist	
<i>Supervisors: Profession or Professional group of supervisees</i>	
Accident Compensation Case Manager	Non-Regulated Social Service Worker
Art Therapist	Occupational Therapist
Community Worker	Osteopath
Counsellor	Police
Educator	Physiotherapist
Dentist	Project Manager
Disability Assessor	Psychologist
Funeral Director	RTLB (Resource Teacher Learning and Behaviour)
Health and Disability Worker	Social Worker
Hearing therapist	Support Worker
Lawyer	Teacher Aide
General Practitioner	Victim Support Worker
Minister (Religion)	Whanau Kia Whakahaere
Not for Profit Manager	Youth Worker
Nurse	

The Data

The data presented in this chapter, organised according to the three themes identified earlier, which were constructed from the thematic analysis of the recorded interviews, are supported and illustrated by quotes from the participants. Individual participants are identified by pseudonym and two sets of initials, one to identify profession and one to identify role. The following Table 6.5 explicates the different initials.

Table 6.5. Participant Profession and Role Identifiers

Profession	Code
Counsellor	C
Mental Health Nurse	MHN
Nurse	N
Nurse Educator	NE
Non-regulated	Non
Occupational therapist	OT
Psychologist	P
Social Worker	SW
Supervisor	S
Teacher	T
Role	Code
Supervisor	R
Supervisee	E

Theme One: Choice and the Development of the Professional Self

It's not to make them all OTs. Well, I still really hold true to my belief the concept of true professional supervision is the place where you can figure and identify your own solutions and negotiate your way through whatever challenges. (Olive, OT, R/E)

The participants in this study were purposeful in their approach to supervision and were committed to professional development and learning as an outcome of the supervision process. Both supervisors and supervisees understood professional accountability and took responsibility for organising their supervision arrangements so as to accommodate the professional needs of the supervisee within those accountabilities. With two exceptions, the supervisees chose their supervisor from a different profession. The choice was driven by the supervisees themselves and was shaped by a quest for particular skills, knowledge or attributes which they often identified as being held by the supervisor and which they wished to access.

Both supervisors and supervisees had expectations of interprofessional supervision which they detailed in their initial contact with the potential supervision partner. This initial contact, which generally comprised careful conversation, took place prior to any agreement to enter into a supervision arrangement and was an opportunity to assess whether the supervision relationship would meet their particular needs and requirements.

When describing the broad goals of interprofessional supervision there was congruence between the supervisors' aims for interprofessional supervision and the outcomes which the supervisees identified.

Interprofessional supervision was understood to be relational and used to consider the processes, structures and systems of practice, as opposed to the clinical detail of practice. Supervisees' self-management, self-care, relationship-management and ongoing professional growth were highlighted and professional identity was central to the discussion. For many supervisors and supervisees a strong professional identity was considered to be a prerequisite for successful engagement in interprofessional supervision. At the same time both supervisors and supervisees reported that interprofessional supervision further developed their sense of understanding and appreciation of their own professions.

A matter of choice – identifying professional needs.

So, I'm thinking, what can I get from outside because I'll soak up all the learning in my own profession and then I'll think how can I be extended and why shouldn't I have what they have to give as well? (Donna, C/SW, E)

The exercise of choice when engaging a supervision partner has commonly been identified as contributing to a successful supervision relationship (O'Donoghue, Munford, & Trlin, 2005). All of the supervisees in this study chose their supervisor and, with two exceptions, were happy to choose someone from a different profession. The factors which influenced practitioners to make this choice varied but held in common a sense of purpose, an understanding of the potential for supervision to contribute to professional growth, the quest to find a supervision relationship which met their needs and a willingness to take responsibility for their choices.

Many supervisees, confident about their profession-based skills and knowledge, sought different knowledge, skills or attributes which they saw residing in, or practised by, other professions.

Why I chose psychotherapy ... I really like the depth of process that psychotherapists work from, and I know some counsellors do but I really like their depth of processing, understanding relation dynamics and I like the theoretical understandings that they bring ... oh just the body of knowledge that they bring. (Alice, C/SW, E)

I guess I deliberately did choose her because she wasn't a nurse. I wasn't really looking for nursing, I wasn't looking at that clinical side. I'm fine

with the clinical side of nursing and I think a lot of nurses get off track a bit and get really quite focused on clinical. (Molly, N, E)

When looking for new skills, the particular profession of the supervisor was not necessarily important.

So, I am more looking for contribution, but if they'd said that there was a psychologist who could offer that, I would have been equally happy to go. (Donna, C/SW, E)

For Nancy and Olive, it was important that the supervisor did not work in their organisation. *"I wanted someone who was external. I wanted someone who had narrative who worked in narrative"* (Nancy, NE, E). *"I was looking for a person completely external from the DHB"* (Olive OT, R/E).

The limitations of small communities and smaller professions were pragmatic factors which also influenced choice. *"It was too hard to find a nursing supervisor in [name of place], it was very difficult"* (Molly, N, E).

Part of the issue around a small community is our networks and knowing each other ... So actually going into another profession really does support, does help that anonymity and that kind of removal out of your space and can be maybe more objective. (Cathy, SW, E)

The two supervisees who had a supervisor from another profession, but for whom interprofessional supervision was not their first choice, were constrained by other factors. For one it was organisational policy: *"That wasn't my choice, it is the organisation's choice who are supervisors and all of them who supervise have a psychology background"* (Jean, SW, E). Unavailability of a same-profession supervisor was the obstacle for the other.

She has a nursing background but she is working as a counsellor now and supervisor ... It was kind of important for me to have a nursing background just to sort of know where I was coming from, just with the nursing I guess. (Winnie, N, E)

Personal attributes of the supervisor – how will they contribute?

While the supervisees sought interprofessional supervision to meet particular aspects, or the developing edges of their practice, the personal attributes of the supervisor were also important. Supervision was viewed as a relational activity where the 'person' was central. *"It was the person first ...It was about finding the right person"* (Cathy, SW, E). For Nick (OT, R/E), the profession was secondary to the relationship. *"At the end of the day I mean*

probably the choice of the individual might be more important to me than the choice of the profession”.

Prior relationship was a common factor in the supervisee decision-making. Supervisees found that previous non-supervision relationships were often the place where knowledge and practice principles were disclosed and shared. *“I had actually got to know her through doing a supervision course and I really liked her style”* (Molly, N, E). *“Because I had known her in a clinical role and the interesting thing with this relationship is it is more about commonality”* (Ursula, Non, E).

Individual supervisees identified specific attributes of their supervisor which aided their choices. *“It was like a breath of fresh air. It was a perspective that I really appreciated”* (Cathy, SW, E). For many this included factors such as trustworthiness and an ability to challenge. *“She was an approachable person... she makes me think of it in a different way. I felt that she would keep good confidentiality, but she would push me as well”* (Karen, OT, E).

I really trusted his ability to maintain the boundaries between us and, yeah, I think it was interesting. It was an interesting process. It took me quite a while to figure out actually who I would trust to have as a supervisor. (Olwyn, P, E)

For some supervisees the choice of supervisor was based on recommendation and reputation. *“So essentially because she had been recommended, warmly recommended”* (Wendy, N, E). *“XX has got a really good reputation ... my colleague was saying how much they appreciated it. So that was what really motivated me”* (Jean, SW, E). Not all supervisees had prior knowledge of the supervisor. Cathy (SW, E) went cold calling. *“No I’d spoken to her on the phone, I didn’t know who she was, I didn’t know her reputation, I hadn’t heard from anybody else about her”.*

Supervisors’ choices – meeting the professional needs.

The willingness of the supervisors to engage in an interprofessional supervision relationship was based on many of the same factors considered by the supervisees, for example the presence of trust and integrity and the potential to develop a relationship. The question of difference in profession however was of less concern. The supervisors’ main focus was on their ability to meet the needs of the supervisee. Supervisors asked themselves, and the supervisees, whether their knowledge, skills and experience were adequate to the task of supervising someone from that different profession. They expressed varying degrees of

appreciation, and sometimes surprise, at being approached by a practitioner for supervision. “*So did I have enough, I mean I was flattered that she wanted to work with me but actually what did I bring to that relationship, what skills did I have*” (Helen, N, R). Liz (P, R) describes her initial response to being asked to supervise someone from another profession and how that has changed over time to become appreciative of the supervisee’s professional development:

So I guess it’s a sense of being flattered, if I’m really honest, initially. Now it is much more about I get an enormous sense of pleasure, well that’s not the right word, achievement, ... when I see the development that some people have. It is just remarkable. (Liz, P, R)

Supervisors reflected on why they were chosen or asked to supervise. For Agnes (C, R) it stemmed from her role and networks. “*You see I think because I was an agency manager for years. That combination is what brought other people in organisational positions into my orbit.*” Leanne (C/S, R) attributed it to her knowledge and practice background and her identity, skills and knowledge as a supervisor:

I got a reputation for supervising basically anybody from any profession. I don’t know why that happened or how it happened and what I found was my supervisees came to see me as a supervisor not for my profession, but for the theoretical and practical background that I was bringing to the table.

As with the supervisees, for some supervisors interprofessional supervision was not initially a choice but rather a pragmatic response to the reality of working in a multidisciplinary environment:

I think in one way it was a necessity. It started when I was doing the supervision course and I was the only occupational therapist in the DHB in mental health... So there was no one to supervise and I needed an opportunity to learn the skills that I was learning ... So I engaged with nurses in terms of learning to do the supervision, but I suppose in some ways it was also at the time I was working in the crises team alongside predominantly nurses and social workers. So I thought there would be some benefit for me as well in terms of my personal growth to do supervision or to supervise someone from a different profession because I was working interdisciplinary. (Sian, OT, R)

Again, as it had been for the supervisees, a previous relationship with the supervision partner was sometimes a factor:

I knew her, so we'd worked together before and I suppose I was aware of some of her strengths and some of her limitations and I thought that I could be helpful in a supervisory relationship as well. I feel I had something to offer. (Bella, C, R)

Similarly, some supervisors acknowledged the advantage of not sharing the same work context but at the same time knowing the work. “.. and the same reason because I'm not doing the work, but I know the work” (Ingrid, P, R). Leanne (C/S, R) thought that the work knowledge often transcended professional knowledge. “So the professional fit, you know, it is interesting how often it is not about their discipline. My supervisees are often reassured if they know that I have some experience in their area of practice”.

All of the supervisors agreed that they had a choice as to whether they would provide supervision but there was less clarity as to whether their supervisees had a similar choice – “it often depended”. Several supervisors described the difficulties of supervising people who have been sent to them for supervision. “I asked him what he took to supervision and that is one of those difficult conversations where he talked about not really wanting supervision. That he had to have it” (Isabelle, P, R).

Sian (OT, R) recalled a situation where there was constrained choice. “There is an expectation that they engage in supervision, but there is certainly an opportunity to choose who they engage with”. In a similar way Irene (C, R) describes being employed to provide supervision because the organisation “could see a matching of my skills and they were looking for a particular set of skill”.

The supervisors, in many cases, were aware that they had been recommended to the potential supervisee, and this did play a part in how they responded:

So again it was probably a thing about being nice to be wanted but perhaps it was a pressure also because they had recommended me. I thought, well, I had better step up and do this now. But there was quite a bit of apprehension thinking, oh you know, stepping out of my comfort zone. Not so much around who he was professionally, but how will he understand supervision and how can I support him in his role to use supervision? (Tony, SW, R)

Initial contact – establishing whether there is a ‘fit’.

It was common practice for the supervision arrangements, which were described, to begin with an initial meeting between the supervisor and the supervisee. This meeting was to determine whether the relationship had the potential to meet the supervisee's needs and to

determine whether there was an appropriate ‘fit’. “Supervisee–supervisor fit strengthens the supervisory relationship [and] that has been shown in empirical studies to be the single most important factor that influences the quality of supervision” (Ducat, Martin, Kumar, Burge, & Abernathy, 2015, p. 5). Fit included bringing together those factors mentioned above: a match of such things as skills, philosophy, needs, expertise and personality. “*Like, I’ll meet with somebody before we put a contract together because they have to get on with me and I have to get on with them. That is probably about the bottom line*” (Agnes, C, R). This meeting was prior to any formal supervision contract or agreement negotiation and, usually, when the supervisor was in private practice, no fee was charged:

I offer the first session free. That is one thing I always do with people. So if people ring and make an inquiry I say that the first session will be at no cost to your organisation. The reason for that session is to meet with each other. For us to meet, for me to talk about who I am, what my background is, and what I can offer. To hear from them what they are looking for and then for us to make a mutual decision around whether we think it is going to be a good match. (Hazel, SW, R)

With my work for a counsellor or someone from another profession, I do more of an assessment whether I have the matching of the skills and experience to provide that. (Irene, C, R)

Supervisees also commented on this process of an initial meeting. The meetings varied in formality but the supervisees approached the meetings knowing what they wanted from supervision and had often done some prior research regarding the supervisor. “*We had a bit of a sussing out by email and I was pretty upfront about what I wanted...*” (Linda, C, E).

So I always do that initial session. I’ve actually not ever not gone with the person after the initial session, but I do a lot of research too. Like I’ll ask who else has had them and what they thought about them and, you know, what their experience was, before I’ll even approach that person. (Donna, C/SW, E)

Sometimes fit included an intuitive element and an assessment of whether there was a potential for trust:

It is a bit of a gut feeling probably. Like I’ll talk to them about what they want, what they want to get out of it, what I think my input needs to be. I talk about difficulties they have run into before [in supervision]. (Agnes, C, R)

Part of that is a gut feeling and honesty is a large part of that and rapport. ...There's the personal fit of the person and then there's the fit of the profession and skill requirements to my background. So when it comes to the fit of the person to person there's the need to feel trust in both directions. I can trust that person and they can trust me would be number one. (Leanne, C/S, R)

The supervisors identified the parameters for accepting or not accepting supervisees. These parameters were wide ranging and included consideration, not only of the supervisor's ability to meet the supervisee's needs, but also the supervisee's ability to engage in the relationship, their reputation in the workforce and the ethical integrity of their practice. Boundary issues were also identified for example friendships or dual relationships with another supervisee:

If I am to supervise them, and what they need is closely tied into aspects of their profession that I'm not familiar enough with, then I don't have the right background for that relationship. Yeah, so I'm looking more for what I'm not going to be able to do for them and whether that is going to be an issue or not. (Leanne, C/S, R)

Some people have reputations for being very negative, difficult and hostile. So if I know there are people who have that reputation I would be hesitant because I have a choice to take those people on. (Hazel, SW, R)

If I thought that the person was having an unsafe practice ethically and they weren't interested in having a look at it, then I wouldn't be prepared to continue with them. (Irene, C, R)

Supervisors were aware of their own particular style, how that might be compromised by different supervisees and that they might end up supervising in a manner which was not to their liking. For some supervisors the choice rested on the question of whether they actually wanted to supervise the person:

If we don't have enough common assumptions to start with, or perhaps if I found they had a very rigid kind of approach, perhaps if they were overly passive, I wouldn't be very keen as well because it might be hard to move out of an expert role then. (Isabelle, P, R)

At one stage I had someone come and see me who was looking for a supervisor and I had a meeting with this person and by the end of it I thought, there is no way I could supervise you. I would drive you batty because our styles, and in some ways our content, was so different, but it was mostly a personal style. (Olwyn, P, R)

Developing the professional.

As has been described, the aim for interprofessional supervision to address the supervisees' professional development was central for all participants and for many supervisees it was the basis from which they chose their supervisor. The supervisees had clearly identified goals, or areas, which they wished to target with their supervisor. For some, this included assistance to help them address generic management and leadership roles which they were undertaking as part of their career development and progression:

To get what I wanted out of supervision I felt that I needed someone who had some leadership because I am now at a point where I am wanting to extend myself professionally from a leadership point of view and utilise and work on those skills as well as clinical ones. (Karen, OT, E)

For others there was a more generic intent. “*Continuing to grow as a professional and not stagnate and get stale... really about career development, I guess, and opportunity*” (Linda, C, E). Supervisors expressed it more generally. “*What I see supervision about is the development of people*” (Liz, P, R). “*I still have a formative kind of focus that we are really there mainly for the development of effective practice whatever the profession is*” (Elaine, C, R).

Participants, both supervisors and supervisees, understood that the focus of interprofessional supervision was at a level beyond the details of clinical practice. Interprofessional supervision focused on the ‘how’ of practice rather than the ‘what’ of practice:

The work is almost secondary to how they do the work. So, what I’m supervising is, yes we are talking about how to manage situations, but actually it is managing themselves in that situation and growing that skill base, confidence, ability to be reflective, ability to understand themselves. (Liz, P, R)

So, that supervision, for her supervising me, that would be slightly different in that her work is not around developing my actual nursing practice but my professional identity and my ability to do my nursing practice well. (Nancy, NE, E)

Leanne’s (C/S,R) expectation was that supervisees would bring specific cases to supervision for discussion. If this did not happen she describes getting “*curious why is it not coming to the table, how aware are they being?*” The focus of discussion again, however, was on the relationships of practice, not on clinical interventions. “*...so that is their interaction with*

their clients, but also reflecting on how their clients are impacting on their sense of self professional and otherwise” (Leanne, C/S, R).

The supervisors described listening to their supervisees’ accounts with an ear which was tuned to the broad principles, rather than the details, of practice:

So I’m listening out ‘are they making good clinical decisions, do they understand the application of their knowledge and are they providing safe care?’ I am listening for that rather than necessarily that intricate knowledge of the discipline. (Sian, OT, R)

Professional identity was discussed by many of the supervisees, who conveyed a strong and robust sense of their own professional knowledge and identification. They invited and welcomed challenge:

So, I probably take a really deep seated knowing of who I am in that space into supervision and I guess that what I am looking for in supervision is to be challenged and to have a space to think about, you know, at another level, from a pair of eyes that are not deeply embedded in that profession. (Linda, C, E)

Engagement with interprofessional supervision for supervisees was described by many as a stage reached on a journey. The acquisition of expertise and the associated development of professional identity were considered to be two indicators of readiness for this stage. Practitioners (supervisees) expressed a robust sense of understanding of who they were, what they wanted from supervision and demonstrated the confidence to decide for themselves what action they would, or would not, take as a result of a supervision conversation. Linda continues, reflecting on the importance of professional and practice experience:

So, in some ways that might be a kind of reflection of seniority and kind of stropiness that I would be happy to say ‘no thanks all the same, that is not an option for me’. Whereas maybe some of our more junior staff, you know, maybe don’t feel they have so much of a choice. (Linda, C, E)

Reflecting earlier research on this topic (Beddoe, 2013; Cruess et al., 2015) professional identity was not seen as static or fixed but rather as something which was open to challenge and development through the interprofessional supervision process. Participants mentioned the value of the ‘external eye’, ‘impartial view’ or ‘different perspective’ which assisted supervisees to consider themselves, their practice and their professions in a new light and from that to strengthen their professional understanding and professional position. At times this understanding arose through the process of explaining themselves to the ‘other’:

The inquiry that comes from somebody who is trying to make sense of something, so therefore I have to get really clear about what it is that I'm talking about. ... I think that is the beauty of interprofessional supervision though. I think it gets you really solid about what your profession is. (Nancy, NE, E)

In keeping with other research (Ibarra, 1999) the supervisees saw their professional identity and their professional practice flexibility developing in response to a breadth of experiences:

Well, I really like the different viewpoint, and, like, just her reactions and, like, especially when you can see [the] point to something new. That kind of thing is really encouraging and safe and [we] can explore things. (Wendy, N, E)

Opportunities is to kind of move you forward and make you see from different perspectives and for another perspective to be brought into the mix in terms of profession. (Karen, OT, E)

Supervisors, too, were thoughtful about their own professional identity in supervision, and were conscious of keeping the boundaries between themselves and their supervisees clear. This, they approached in different ways. For Olive (OT, R/E) it was to ensure that the identities did not become confused. “*So probably one of the strongest values that I hold about interprofessional because it is not about our identity it's about your identity, and I've got my own identity*”. Irene (C, R) on the other hand, viewed her professional identity as an integral part of who she was, and for her it was important for this to be present in the supervision relationship:

So, I guess when I think about my profession it is very hard to separate it out from who I am to be honest. And what is really important is for whoever is sitting with me to actually see who I am and to see my genuine interest in who they are.

Both supervisors and supervisees recognised that interprofessional supervision required supervisees to have a strong professional base of knowledge, professional confidence and professional identity. To this end, and again echoing concerns raised in previous research in this area (Pollard et al., 2006; Yang et al., 2017), many did not believe that interprofessional supervision was an appropriate form of supervision for students. One of the key tasks for students, they argued, was to form and develop a professional identity. In the supervision of students, the supervisor, they believed played a significant role in both promoting and modelling this identity.

I don't think it should happen with students of a discipline that you don't belong to. So I could never provide interprofessional supervision for social work, chaplaincy, other students and I think that is because you are helping them identify their professional identity and to do that you need to have a really clear professional identity yourself [in that profession]. (Elsie, N/C, R)

Similar reservations, also recorded in the interprofessional supervision literature (Beddoe & Howard, 2012; Bogo et al., 2011; Cassedy et al., 2001; Crocket, Cahill et al., 2009; Mullarkey et al., 2001; Simmons et al., 2007), were expressed regarding interprofessional supervision for those newly graduated into their profession.

I think that when junior OTs come out, I think that they should be supervised by an OT. Mainly because they only get so much at Uni and I think they need to get a little bit of a foundation before then branching out. ... like a lot of their supervision is around cases ... make sure they are pushed as an OT, you know, we are ensuring they have got those foundational skills to then grow. (Karen, OT, E)

Elsie (N/C, R) expressed it more forcefully. *"I believe that if they are new graduates that they absolutely have to have someone from the same profession and I think it would be unethical to be the primary supervisor in that setting"*. Although she is not a new graduate Jean (SW, E), who worked in a multidisciplinary team and who did not choose interprofessional supervision, identified her need for same-profession supervision in her work place.

For me, what I ask is, I have two very clear goals for social work supervision. One of them is I would like to apply for registration and the other one is to maintain my identity as a social worker because I really struggle with that, right now I am struggling with that.

Some participants, however, worked around this limitation of interprofessional supervision by identifying adjunctive supervision, or regular meetings with same-profession clinical leaders, which, for new graduates, could supplement interprofessional supervision. *"But I still don't think, you know, that you wouldn't do it in that circumstance as long as the person also had access to other ways to become familiar with the culture of their profession"* (Linda, C, E).

Lack of experience of supervision was also seen to contribute to the challenge of interprofessional supervision for the new graduate. Nancy (NE, E) posed the scenario of a supervisee, new to supervision and to the profession, and the potential for him or her to

become confused by the supervision process if the supervisor did not have a foundation in, or knowledge of, the supervisee's profession.

New to the art of their profession, going along to supervision and a nurse could easily get themselves a bit lost in conversations around actually what is it they are meant to be doing with somebody, if they don't know what it is that their role is. (Nancy, NE, E)

Theme Two: Interprofessional Supervision: A Structured Process

The understanding of supervision as a profession in its own right, a profession accompanied by supervision specific skills, knowledge and values, is a central theme of the research. Participants approached the issue of professional difference in a variety of ways but there was an underlying proposition, at some times more explicit than at other times, that supervision was a practice which transcended profession and thus accommodated difference as part of that practice of supervision. *“As long as you've got that core understanding of what supervision is and agreement about what supervision is then it really shouldn't make a difference, I don't think”* (Cathy, SW, E).

Through its structure and process, interprofessional supervision was seen to be distinguishable as a particular form of professional supervision, The *structure* of interprofessional supervision, as described by the participants, had clear boundaries, acknowledged limitations and articulated mechanisms to ensure clinical and/or organisational accountability. The *process*, as described, was supervisee driven, facilitated by the supervisor and shaped by affirmative, reflective enquiry. A portfolio approach to professional supervision was common where both supervisors and supervisees identified adjunctive supervision, or supervision type meetings, which complemented the work of interprofessional supervision.

Role clarity.

Two of the participants introduced themselves professionally as supervisors and others, both supervisees and supervisors, distinguished between the practice of their profession(s) and the practice of supervision. The different roles, assumed in each of those forms of practice, were of importance. This distinction had two levels. The first level was the understanding that the role, which the supervisor assumes within the practice of supervision, is different to that person's role in professional practice. In short, the supervision relationship and the supervision process regards the practitioner as a supervisee, not a client. Leanne, (C/S, R) illustrated this in the following way. *“So, I would identify myself as a supervisor and I*

generally run through, if someone asks me 'so what do you do in supervision?' One of the first things I say is 'I don't do counselling'". Olive (OT, R/E) saw a more critical need for the management of role seepage. In her view, it was essential that supervisors made the shift from a *discipline* informed focus to a *supervision* informed focus when supervising. This was not because she was concerned that supervisors would direct their professional skills onto the supervisee, but rather that, not respecting different professional scopes of practice and knowledge, they would view the supervisee's practice through their own profession's lens and find fault. In line with early supervision literature, for example Borders (1993), Olive saw supervision training as necessary to ensure that supervisors had the understanding and framework to make this shift.

Olive illustrated her point with the example of an occupational therapist who, supervised by a psychologist, was being directed to intervene clinically with a patient in manner which did not accord with occupational therapy practice:

So, I think there is the massive risk that if there are professions that aren't trained [in supervision] then they are going to be expecting clinical practice based on their paradigm and it destabilises a different profession. I do feel quite strongly about that. (Olive, OT, R/E)

The functions of supervision.

Notwithstanding the differences, the basic structure of interprofessional supervision shared much in common with general models of supervision. Despite a lack of shared profession, and despite the acknowledgment that the technical and clinical aspects of practice were not the primary focus of interprofessional supervision, the broad aims of supervision for these participants fitted within the traditions of functional or task models of supervision.

As introduced in chapter two, these models generally name three functions. The educative (Kadushin, 1992; Morrison, 1993), which addresses the on-going professional skill development and knowledge resourcing of the practitioner; the supportive (Kadushin, 1992; Morrison, 1993), which attends to the more personal relationship between the practitioner and the work context and how this impacts on the practitioner; and the administrative (Kadushin, 1992) or managerial (Morrison, 1993), which describes the practitioner and supervisor's accountability to the policies, protocols, ethics and standards which are prescribed by organisations, legislation, professional and regulatory bodies. Proctor (2001), similarly refers to the formative, restorative, and normative "tasks and responsibilities of supervisor and practitioner" (p. 25). The application of these functional models to interprofessional supervision does not diminish their reach but rather, as explicit in Proctor's

early formulation of her model (Inskipp & Proctor, 1993), the tasks are “the shared responsibility of [the] supervisor and [supervisee]” (p. 6). This collaboration, or sharing of responsibility, is one of the central characteristics of interprofessional supervision. The functions or tasks of supervision thus can be considered to define the territory of supervision where the supervisor and the supervisee, in collaboration, share the responsibility for addressing those functions.

The particular and specified aims of the interprofessional supervision arrangements, as described by both supervisors and supervisees, were similar. The aim of professional development, the educative function or the formative task of supervision, which has been discussed in the preceding section, joins with the participants’ wish for support and for accountability within the interprofessional exchange.

Supervisors saw their role as one of support. Often that support was viewed as enabling, facilitating and ensuring self-care and development. *“Yeah, I am there to support the development of their practice and also within that to support their wellbeing in their practice and the relationships that they have”* (Irene, C, R). For others the support included an active form of caring and attending to the supervisee’s needs. *“And so it’s supporting her emotionally and spiritually and the work that she does. It is identifying any other support that would enable her to do the work that she does”* (Elsie, N/C, R). For Nick (OT) as a supervisee, this form of support was important. He described the aim of interprofessional supervision for him as *“basically a support for me to be able to feel good about what I do and to be able to manage the stress”*.

The managerial function, or normative task, of supervision also featured. High on the list of aims for interprofessional supervision were safety and ethical practice alongside self-care. These objectives were seen by many supervisors as interconnected. *“Well, first and foremost safety always and ensuring that my supervisees are staying safe themselves, practicing safely”* (Leanne, C/S, R). Safety was linked to ethical practice. *“Their safety and the safety of others is one aim so that is kind of at an ethical level”* (Ingrid, P, R). Wendy (N, E) wanted her supervision to ensure ethical practice through attention to boundaries, while Hazel (SW, R) spoke of accountability to self, the profession and to the organisation. Self-care, as a responsibility of safe practice, was mentioned. *“I’m interested in looking after their self-care and making sure that they are actually managing their practice whatever that is”* (Ingrid, P, R). *“Self-care is a huge part of that as well and also particularly if it relates to internal dynamics or changes that are happening”* (Hazel, SW, R).

It is with regard to the managerial or normative functions that the interprofessional supervision, which was described, included additional practices to those commonly employed in same-profession arrangements. The normative task “highlights the importance of professional and organisational standards and the need for competence and accountability” (Bond & Holland, 2010, p. 18). This level of accountability is more complicated for a supervisor who does not share the same profession as the supervisee and who is maybe located outside of the organisation.

For O’Donoghue (2004) “duty to clients concerning accountable practice, continuing professional education and professional standards” present the “main ethical issue for social workers engaging in cross-disciplinary supervision” (p. 5). Professional accountability in interprofessional supervision was recognised as important by the participants and was addressed in a number of ways. The first was by identifying the codes and practice standards to which each party, supervisor and supervisee, were professionally accountable. “*We had a physical contract that outlined the ethical principles that I work under*” (Bella, C, R).

I think it would be making sure I had a copy of the physiotherapy standards of practice and code of conduct, or, if it was a social worker being very clear about the ANZASW [standards]. Whereas for the chaplain I have a job description, but his religious and spiritual work is something that the spiritual director works with. (Elsie, N/C, R)

So, a conversation around what is important in terms of nursing conduct and ethics and professional obligations ... and how we might navigate that in terms of this was professional supervision, but it was across disciplines. (Nancy, NE, E)

The second was to identify the person(s) to whom the supervisee was professionally and clinically accountable. For Nancy (NE, E) this was to “*ensure they have somebody of the discipline ... who had the expertise and skills to be able to support them and the conversations around that clinical piece of work*”. In a similar way Tony (SW, R) believed that interprofessional supervision “*would need to be complemented by someone that has that practice wisdom and that professional wisdom*”. Liz (P, R) made this a requirement of interprofessional supervision. “*... and one of my rules is they have to have another form of support or supervision that is specific to their [profession]*”. Other supervisors considered organisational accountability. “*Do we need to talk about, for instance, my reporting relationship to your institution or organisation and really understand what our roles are here?*” (Leanne, C/S, R). Ingrid (P, R) asked for a map of the supervisee’s lines of accountability “*so I would write down the names of their external supervisors and I usually*

know who their immediate bosses are and where they fit within a system". Bella (C, R), made clear that she was not a clinical case management supervisor and negotiated boundaries around clinical conversations. "We wouldn't be talking about cases unless there was some kind of management or overseeing or staff role what came up".

Notwithstanding the boundaries identified, and the roles which were negotiated between the supervision parties, many of the supervisors recognised that, from time to time, clinical issues did find their way into interprofessional supervision conversations. Here, it was not only the supervisee who consulted with clinical experts, and Sian (OT, R) describes her own process for ensuring that her knowledge was adequate:

But I suppose also, if I am concerned ... I would check with a senior like the clinical nurse director. So, if I was unsure I would go to someone who is a nurse and double check. (Sian, OT, R)

Occasionally, issues had been identified as matters of concern, safety or risk. Hazel and Irene described what they saw as their responsibility to address clinical issues, in certain circumstances, even though they did not have clinical responsibility for the supervisee's work:

So, once again I'm clear ethically if I feel I'm holding risk ... I will follow that up. I'm not going to hold it and say, 'I gave it to you and you decided differently'. I'll be an educator, you know, I'll say 'have you heard of dangerous dynamics? If we looked at it through this lens...' And in this case the person said 'wow that is new to me and I can see exactly what we're doing here'. (Hazel, SW, R)

So, if I heard of anything that was of concern and was of risk that I did not think there is a manager or a nurse that is covering that. It is my responsibility to man that and make sure there is a plan around that. (Irene, C, R)

Professional accountability worked two ways and Agnes (C, R) described her need to be persistent and firm when addressing behaviour, which was clearly unethical from her professional (and her profession's) perspective, but which her supervisee (and that supervisee's organisation) did not recognise as such:

So, I kept bringing it up, like every time we met I would just inquire as to the thinking and what was happening and how it was going, you know, and it's hard. It was actually very hard ... Well I'm a member of an organisation and there are certain ethical guidelines and boundaries ... Yeah, it wasn't OK as far as I was concerned therefore, for me, it doesn't

matter how prominent somebody might be ... where their behaviour is not alright in my view, or in the view of the NZAC is dangerous. (Agnes, C, R)

Not all supervisors saw that difference of profession required any different action to be taken. Amy (MHN, R) believed that:

Because, I guess, generally people resolve issues or queries in a similar way no matter what their discipline. They would either seek advice from their professional leader or report something if it needed reporting. To me, it would be a similar within organisations.

Negotiating the supervision agreement.

Following the initial contact and conversation, participants described a process or conversation where they negotiated and established the supervision agreement or contract. The supervision contract has been succinctly described by Morrison (1993) as “a means of making explicit the aims of the parties to work towards agreed goals in agreed ways” (p. 29). It was in this negotiation and conversation that the details of professional accountability (discussed above) would be determined and agreed. This process, however, varied considerably, in both focus and formality, from one dyad to another. Some negotiations were comprehensive and resulted in a formal written document:

No, I think I have learnt things over the years which have made me become very, very explicit and in my contract. It is interesting, I had a manager refuse to sign my contract until I explained to them what it meant because the exceptions to confidentiality I have in there, you know, and their responsibilities to let me know around ethical [issues]. (Hazel, SW, R)

Other partnerships relied on a verbal contract. “*I guess as a supervisee we had quite an in-depth conversation around expectations, around protocols and things, but there was no document, like we didn't have a written contract*” (Olwyn, P, E). Liz (P, R) describes the different ways in which she has approached the negotiation of supervision contracts:

I have tried ‘what do we need to have in the contract?’ at one end of the continuum through to ‘here's a form let's talk it through’. I now fall somewhere in the middle where I have a set of questions ‘who are we, what are we doing, how are we going to do it, what might go wrong?’ and some people go away and fill in what are their goals, you know, fill it out really carefully and we have a bit of a conversation. Liz (P, R)

Participants identified a range of items which were addressed in the contracting conversations and detailed in the supervision agreements/contracts, most of which, as many

of the participants noted, were similar to same-profession supervision agreements/contracts. The contracts included such things as confidentiality and its limitations, record keeping, the pragmatics of venue, frequency, length of session and, where appropriate, cost. Addressing inappropriate or unsafe practice, should it arise, was usually detailed and accompanied by an explicit process. *“We always talk about things like how documentation will be kept, confidentiality and how I would I go about addressing anything I might be concerned about and how that would be escalated if ever needed”* (Sian, OT, R). Expectations of attendance and preparation were specified along with particular goals which the supervisee wished to address in supervision. The contracting conversations sometimes included candid disclosure of the limitations and boundaries of knowledge:

No, I think as long as people have a contract and they are clear what they are getting involved in and the knowledge of each party and the limitation of the knowledge of each party then I think it is quite clear. (Molly, N, E)

For some, the contracting conversation was ongoing and developed over time. *“So ... we had a big conversation about that. And I continue to have that, it’s an ongoing conversation around regarding those boundaries I suppose”* (Cathy, SW, R).

The supervision process.

An aim of interprofessional supervision was, in the view of the participants, to create a space within which the supervisee could reflect. This space was variously described as a safe place, a neutral space, a learning space, a place where supervisees could speak honestly:

I am creating that space for them to reflect and work within their scope of practice, which I need to be aware I may not fully understand. So, I have to be guided with them and their knowledge and the understanding of their scope of practice and their level of experience. (Sian, OT, R)

For Linda, the space provided opportunity for the mutual learning of both supervisor and supervisee. *“Well, I guess I kind of see supervision as a learning space and it probably is a learning space for the supervisor as well as the supervisee when it is people from two different disciplines”* (Linda, C, E).

Responsibility for the ‘how’ of practice was a joint venture. Within the profession space specific issues were explored together, and as Sian notes above, supervisors acknowledged and consciously worked around their own knowledge, or lack of knowledge. The supervisors assisted supervisees to identify and work from within their particular professional scope of practice, professional knowledge, ethics and standards of practice. When this knowledge, or

a detail of practice was not able to be identified, as agreed at the point of contracting the supervisee consulted a nominated professional expert or the specific codes of professional competencies:

I don't think it matters if it's a nurse or OT, I'll say, 'I want you to go back to your OT process'. I've said it to the nurse, 'I want you to go back to your nursing process. What would you do?' (Olive, OT, R/E)

So, what does your code of ethics say? It's not completely missing but I don't always know their code of ethics the way I know my own. (Elaine, C, R)

Skills and interventions.

Almost without exception, each of the participants in this study identified open questions and reflective listening as the foundation of their supervision processes. *“Just the reflective skills. So, the open questions, the active listening and the minimal encouragers, the prompts to keep them talking about the issue”* (Tony, SW, R). Ursula (Non, E) valued her supervisor's ability to listen and accurately paraphrase. This encouraged her exploration of the issue(s) and at the same time kept her focussed. *“So, her ability, I guess, to be that reflective practitioner and enabling me and she keeps me in the moment. Like, I tend to race around, but she can bring me back”* (Ursula, Non, E). Many supervisors described their supervision practice, and the types of questions they asked, as being based on particular reflective learning models of supervision. *“Obviously, good old reflective learning model, definitely focusing questions always at the beginning or going at those again later”* (Isabelle, P, R). And Hazel (SW, R) *“with the other professions, yeah, I'm more likely to use, you know, reflective learning model being clear about, you know... So I might use models of reflective practice to help us work through something to an end”*.

Drawing from their own professional skills and practice base, supervisors named or labelled the manner in which they asked questions. Leanne, (C/S, R) based her questioning approach on appreciative inquiry. *“I would take an attitude of being humble, of asking questions when I don't understand or don't know, and engaging in appreciative inquiry, and bringing the difference into the conversation in a very open and deliberate manner”*. Others worked from a strengths approach. *“I am very keen to get people to celebrate. To bring something that has gone well so that they can repeat and learn from that and consolidate that”* (Sian, OT, R). *“So yeah, the thing I try hardest to do is probably to use a strength based questioning and that sort of thing quite a bit, but it is often woven into the conversation”* (Isabelle, P, R). Motivational interviewing, naïve enquiry, narrative discourse analysis and acceptance

commitment therapy (ACT) were also mentioned as the basis for questions and exploration in supervision. At times, the supervisor's interventions were seen as a direct reflection of their professional practice:

I feel like she is using her counselling skills ... those skills that are about encouraging somebody to unpack something and asking questions that make you think about it in a way that you haven't necessarily thought about it before. (Linda, C, E)

Other specific skills and techniques were named by both supervisors and supervisees:

Other sorts of narrative strategies, there is quite a bit of reflective work along the story telling, yeah, and I guess that is externalising conversations. (Nancy, NE, E)

Sometimes she'll draw me diagrams to explain things because I said to her I was quite visual and so she comes with, you know, knowing that she'll have to draw things. (Karen, OT, E)

These techniques were not always immediately comfortable for the supervisee, even though their value was appreciated. *"Sometimes she makes me do role play ... And they are really useful. So that is really different and I find [it] really difficult"* (Wendy, N, E). Agnes was mindful of this and took care to fit the approach to the supervisee. *"So, I might do that in various different ways. Or if they are up for it, it might be psychodramatically or two chair stuff or stuff like that"* (Agnes, C, R).

Supervision portfolios.

Supervision portfolios, where practitioners access different forms of supervision (or different meetings to address clinical and professional accountability), have long been promoted in the supervision literature (Beddoe & Davys, 2016; Garrett & Barretta-Herman, 1995; O'Donoghue 2015). In this study interprofessional supervision was not the sole form of supervision for a majority of the supervisees. Elsie (N/C, R) explains:

But, for the vicar, I think having that spiritual director is critical and I think, you know, there is no reason that people can't have different supervisors for different purposes. So they may well have every other month one to one supervision and the following month the other type.

Eleven of the 14 supervisees (79%) had other forms of supervision, meetings with clinical/practice leaders and/or managers and 90% of supervisors could identify an adjunctive supervision *type* relationship with which their supervisee(s) engaged. Whilst the

primary purpose of many of these meetings was to provide clinical or profession-specific accountability, other reasons were also proffered. At times this was to cover very specific aspects of practice and might incorporate more than one other supervision arrangement. Cathy (SW, E) described peer supervision for her supervision practice, external supervision for her educator role and cultural supervision for work with other ethnicities.

These adjunctive forms of supervision were typically of the same frequency as the interprofessional supervision. Olive's (OT, R/E) description of her management supervision is typical:

No, my manager, we meet monthly. So probably management supervision, he would provide that, yeah. And that is quite formal in the sense that it doesn't give you that professional supervision. It is a formal supervision making sure, you know. I present my work where I'm at and update him on that and I will actively ask for feedback so that I can actually develop more leadership skills more reflectively.

Participants who believed that their professional or regulatory body required same-profession supervision commonly reported a same-profession peer supervision relationship or supervision from the same-profession clinical leader to cover this. Some of the participants received academic supervision for master or doctoral study and Karen (OT, E) described a process of self-supervision:

Every single day I reflect and I almost supervise myself because I'm asking all these questions all the time about what I can do and how I can do better and what went good and what went bad and all of that type of thing. Then, if I'm still in a little turmoil then I'd ad hoc and go and find someone to have that problem solving with.

Not all participants were happy with these other arrangements and Donna's (C/SW, E) comments highlight both differences in understanding about the purpose and function of supervision and the manner in which it is conducted:

We had that internal line management thing going on but I don't know if I would actually call that supervision. I would call it more like bullying, but there you go... We call it line management as regards the person who is directly above you basically telling you why they don't like you.

Theme Three: Diversity as a Vehicle for Learning

Interprofessional supervision occurs between two people who do not share a professional base. Encounters of difference of knowledge, skills, codes and protocols for practice,

attitudes and, at times, values are therefore common. For the supervisors and supervisees in this study, most of whom had chosen their supervision partner, difference however was not considered an impediment to their supervision process and in many cases difference was identified as a source of stimulation, excitement and growth. *“I’m not into ‘you’re this and I’m that’. I’m into ‘we share common ground’ and if we don’t, you know, how exciting is that let’s explore”* (Donna, C/SW, E).

Participants described their interprofessional supervision experiences with energy and enthusiasm. Both supervisors and supervisees reported that they learned from the supervision exchange and that they valued and welcomed the opportunity to view their professional world from different perspectives. The learning was different for each group, supervisors and supervisees, but learning for each was based on the richness of diversity.

The supervisors’ motivation to engage in interprofessional supervision stemmed from a number of sources which included learning from different perspectives and redefining their own professional understanding. *“It makes you think about your own profession as well and it does open your eyes to others perspectives”* (Helen, N, R). Excitement was also present *“...knowing that I could meet their needs and feeling quite excited about being able to do that and sort of stretching myself and doing something to build on what I was already doing”* (April, C/SW/T/S, R).

The challenge of interprofessional supervision, which required a greater focus on the process of supervision, was noted and appreciated:

It is probably a little bit more stimulating at times, just because I’m interested in the supervision process and how the supervision process works. And because of that, that is highlighted in interprofessional supervision for me as a sort of ‘how am I working here, how is this working and what do I need to be doing in this scenario?’ I’d be thinking more about that so that keeps me on an edge and hopefully then that is the experience for them too. (Isabelle, P, R)

Working with difference.

Some supervisors identified the personal challenge, and the accompanying satisfaction and stimulation, which came from supervising across professions.

I was brought up in a different religious culture. How am I going to actually possibly put my foot down with this person, who holds quite a high office within the ministry, you know, and the usual ‘how dare I?’Like, how dare I? Yeah I thought it would be interesting really. (Agnes, C, R)

Yeah, I guess as part of my professional practice, things that I value highly are things around patient centred care. So, to work to sort of support somebody representing patients, that was really important to me. I liked the opportunity to be able to do that. (Amy, MHN, R)

When considering the management of difference within the supervision relationship participants described a range of strategies. Establishing commonality was often a first step. *“I think with some of the people who aren’t social workers, one of the things I try to find with them is the sort of common values”* (Hazel, SW, R). A general belief that, at a foundational level, values, principles of practice and ethics were shared was also evident:

Well, I think the same ethical principles apply across professions, you know, do no harm, do good, the fairness, the social justice. I think those things are still relevant across all professions. (Elsie, N/C, R)

Difference was commonly acknowledged, and its place within the supervision relationship and the supervision process was articulated, at the outset of the supervision relationship. As Elsie demonstrates, this conversation about difference not only provided the ground rules for how difference would be addressed but also laid the foundations of a respectful and collaborative supervision process where the supervisee’s opinions would be valued:

I have a very strong view about things being different and not right and wrong and so we had that discussion quite early that we might hold those different views and it is one of exploring the difference and the meaning of it and different perspectives. What different perspectives, the value of different perspectives in a situation. (Elsie, N/C, R)

Supervisors were open to learning alongside supervisees and learning was seen as a two-way process. *“She will often say ‘well actually I’m learning from you’ So it’s respecting the difference and, yeah, being open to name differences if we see them”* (Ursula, Non, E). *“Because I think what happens is that we educate each other around that, and we negotiate those differences, and talk about them”* (Cathy, SW, E).

Difference, which at times created uncertainty and not knowing, at the same time prompted the participants to be curious and to explore. For Leanne (C/S, R) this became an opportunity for co-exploration:

..and it was kind of like her and I engaging in that almost investigative process together and having that support that meant that was a better relationship for her than if she had rocked up to someone who was a dentist and assumed all that stuff ... We both didn’t understand so we both figured it out together. (Leanne, C/S, R)

At times the *not knowing* created a platform for questions, clarification and challenge which extended the supervisee and promoted deeper understanding and critique:

It was actually helpful because the questions that came were not from a knowing of 'oh this is what you would do it', but rather 'well that is interesting, why is that?' (Nancy, NE, E)

If I say 'what do you mean by that?' and they've got to account for it, sometimes it gives them the possibility of critiquing what they are doing. (Elaine, C, R)

This ability to tolerate *not knowing*, which is identified in the literature as key to the promotion of critical reflection (Ruch, 2009), was discussed by many participants. When differences were uncovered in the supervision session participants recounted conversations which were inclusive, collaborative and which acknowledged the value of a range of approaches. Differences were approached with curiosity and a search for a solution which was appropriate to the situation:

As differences came up it was more about a conversation around 'oh you do it that way? We do it this way' or, you know, and then thinking about how could we bring aspects of your way into that and vice versa. (Linda, C, E)

Participants reported exchanges about difference which were indicative of the presence of solid supervision relationships which could accommodate humour, and at times, good natured sarcasm:

I think once we had worked through that, we much more valued our differences and I think that is a good place to be, yeah. 'Oh my god you are such a nurse' and it is that sense of 'oh you and your caring ways'. (Olive, OT, R/E)

Whilst the participants discussed the differences between professions, and the ways in which these differences impacted on their supervision process, it became apparent that interprofessional differences were but one group of a number of differences which needed to be acknowledged and accommodated within supervision. For the men in the study gender difference, or rather gender similarity was important. Nick (OT, R/E) found that being a male in a female dominated profession was more of an obstacle than being in a supervision relationship with someone from another profession:

I do relate professionally but there is a lot more relating going on amongst those women that I don't get into and with a social worker who is male

I've got a lot more in common with him than those women who are in the majority. Nick (OT, R/E)

As a supervisor, Tony (SW) saw that commonality of gender was the component that engaged his supervisee and transcended a range of other differences including different profession”

And I think one of the key things in that formula was perhaps not the difference, but the similarities i.e. he was slightly older than me, he is from a number of ethnic origins, but I think the key element was he was talking to a man as opposed to a lot of female colleagues, and god forbid a lot of female social workers. (Tony, SW, R)

Donna (C/SW, E) describes an exchange with her supervisor about ethnicity:

I guess that she is very Pākehā in her upbringing and the way she lives and she wanted to know, you know, how would that be for me and how would we negotiate that. And I said that it is 'All good. Everybody should bring themselves and [you] can't bring anybody else and I'm interested in what you've got to give'. (Donna, C/SW, E)

The range of *other* differences which were identified also included: age, experience, values, beliefs, sexual orientation, personality and whether the supervisor was from within the organisation (and the role they held) or external to the organisation. All of these differences were seen to impact both the supervision relationship and the supervision process. In the opinion of the participants these differences were as relevant to the experience and practice of supervision as any difference of profession. Some differences were seen to be more evident than others and Isabelle (P, R) warned about supervisors becoming complacent:

It is a bit like cross cultural, well it is more obvious with cross cultural, you know, the blind spots that a supervisor might have ... And so someone who is not on the lookout for those, who is too sure of themselves and has a sense of rightness about their occupation which most of us have, which has got to be tempered. (Isabelle, P, R)

As with difference of profession, these *other* differences were usually identified and discussed early in the supervision relationship. Participants noted that being of the same profession as the supervision partner was no guarantee for common knowledge and understanding. Ingrid, a psychologist, spoke of supervising someone from another discipline within psychology:

I've got a community psychologist at the moment who is just not quite qualified and is working in organisations that provide programmes for

people with disability and I don't know community psychology, it is like a foreign language to me. In a way it is a bit like same thing you get within interprofessional things. (Ingrid, P, R)

Difference of education and training were also raised. This difference particularly related to those supervisees who did not belong to a recognised profession, but rather worked in the non-regulated health and social service workforce. As Isabelle (P, R) observes with honest candour, the presence or absence of education can work in two directions:

Yeah, and I think that is probably more so with somebody like a victim advisor who wouldn't have high degrees of training as opposed to other types of professionals who would have all of that as background as well. ... but I can also feel it the opposite way as well. I can be sometimes intimidated by somebody else's abilities in those ways. So, you know, it can go the reverse and then I sort of clam up myself. (Isabelle, P, R)

The context of supervisees' practice was also a factor for some supervisors. Organisational values and policy at times impacted on professional practice in a manner which was independent of profession but nevertheless required examination and understanding within the supervision process:

I supervise somebody from [named institution], totally different culture. Not always easy ... because they have a mandate which is to save the money. It is quite different and sometimes it is quite hard because sometimes they have to subscribe to that mandate. (Agnes, C, R)

For the participants in this study difference, which offered opportunity for growth and introduced new ideas to both parties, was highly valued. “*Absolutely, and the difference might bring value for either of us in how we see something, in the skills that we take away, the understanding we take away from the discussion*” (Elsie, N/C, R).

Interprofessional conversations.

Supervisors and supervisees considered their interprofessional conversations and how those conversations may have been different if they had been between two people from the same profession. Common to the reports from many of the participants was an awareness of what they saw as the *trap of making assumptions*. Linda and Nancy described working with a supervisor from their same professions where assumptions about knowledge, practice or standards limited and shut down exploration. On the other hand, when supervised by a supervisor from a different profession, they found that the supervisor's not-knowing and curiosity were beneficial:

Well, I guess that you probably make assumptions that you don't realise that you are making because you think that you know how it all works. Whereas with a supervisor from a different discipline they are more likely to ask about 'why do you do it that way'? Whereas, you know, when you are inside the profession you are probably just making an assumption that 'it's done that way because that's the way it's done'. (Linda, C, E)

So, I found it really useful because one of the things that happens immediately is you default to 'OK, well nurses just do this and this is what you are meant to do' verses someone saying 'well that's curious and what would be informing that?' (Nancy, NE, E)

Supervisors were also alert to the dangers of assuming similarity in more generic areas, as Liz (P, R) describes:

While we assume they are similar, they are not quite the same ... That is a difficulty. I was thinking about ethics, we can't assume, I can't assume that people sitting in front of me have the same ethics that I have and I can't assume they don't have the same training. So I have to be able to park that and find out what it is. (Liz, P, R)

Cathy (SW, E) who had worked in an area of practice which had high public profile, identified a different area of assumption which coloured her supervisor's approach and which had the potential to shape the supervision process in a manner which was not necessarily useful:

She had some assumptions about it as well about how difficult it was. She had heard stories about how horrendous it might be to work there. So she maybe had some assumptions of what I might need from supervision based on that...but she couldn't get past that... She probably saw things that I didn't see or whatever. (Cathy, SW, E)

The following table (Table 6.6) draws together and summarises the characteristics of interprofessional supervision as reported by the expert informants.

Table 6.6. Summary of the Phase Two Data

Interprofessional supervision Reported	
Characteristic	<i>Phase two interviews</i>
Training	Supervision training and knowledge are essential for supervisors and preferable for supervisees.
Experience	Interprofessional supervision is best accessed by practitioners (supervisees) who possess expertise, practice competence and a well-developed professional identity.
Choice	The ability, or the freedom, to choose a supervision partner and whether to engage in that particular supervision relationship is of particular importance.
Initial Meeting	The importance of an initial meeting between the supervisor and the supervisee to determine whether the relationship has the potential to meet the supervisee's needs and for both parties to determine whether there is an appropriate 'fit' of expectations, skills, values and personality.
The Supervision Agreement/ Contract	The expectations and parameters of supervision are negotiated and the limitations and boundaries of knowledge are disclosed.
Difference	Commonly identified, and strategies developed to manage it, when supervision agreements/contracts are set in place at the beginning of the supervision relationship.
Professional Accountability	The supervisee's accountability to his or her own profession is acknowledged and additional relationships and/or people are identified to ensure that this responsibility is addressed and that the supervisee has appropriate access to profession specific knowledge. This is commonly discussed in contracting session.
Supervisor Role Clarity	Interprofessional supervision has a <i>supervision informed</i> focus rather than a <i>discipline informed</i> focus.
The Supervision Process	To create a space, or a learning place, where the supervisee could safely and honestly reflect.
Trust and Respect	Interprofessional supervision is based on a trusting and respectful relationship.
Support	Supervisors took a supportive role in interprofessional supervision.
Skills and Interventions	Topics for discussion were led by the supervisee and facilitated by the supervisor through open questions, active listening and reflective enquiry.
Professional development and growth	Professional development and growth were considered to be the central aims of interprofessional supervision. The main focus on interprofessional supervision was on the processes, structures and systems of practice rather than the details of clinical practice this included: the supervisees' self-management, self-care, relationship-management and professional identity.
Functions of Supervision	A central characteristic of interprofessional supervision was that the responsibility for ensuring that the various functions of supervision were addressed was shared between the two participants, supervisor and supervisee.
Supervision portfolios	Practitioners access different forms of supervision and other professional relationships were considered to be important.

Interprofessional Conversations	The differences in profession between supervisor and supervisee assisted them to avoid the trap of making assumptions.
Professional Identity	Interprofessional supervision further developed a sense of understanding and appreciation of participants' own professions.
Supervision as a professional practice	Supervision was considered as a professional practice in its own right which transcends individual and separate professions

Characteristics of Interprofessional Supervision

At the conclusion of the interviews the participants were asked to identify the benefits and challenges of interprofessional supervision and the qualities needed by those who engage in this mode of supervision.

Benefits.

When considering the benefits of interprofessional supervision participants detailed a range of factors, many of which mirrored their initial reasons for choosing to engage in this form of supervision. High on the list for supervisees was the benefit of new eyes and different perspectives which encouraged exploration. The difference in profession brought an additional freedom for supervisees, who found it liberating to engage in a professional conversation with a person who was outside of both their professional system and professional relationships:

You get a different perspective, well for me it is external to all the other stuff that I'm involved with, so that's a real benefit like she doesn't know the people or the system or all of that. So, it's like fresh eyes. (Wendy, N, E)

Many supervisees were employed in multidisciplinary work contexts. Learning from, and about, another profession in supervision was considered to be of value to ongoing interprofessional relationships. This, in Nancy's experience, not only reduced interprofessional defensiveness, but also assisted supervisees to strengthen their own professional identity:

Because I believe interprofessional supervision is a really good thing and the reason I think it is a really good thing is because for me it minimises some of the defensiveness across the disciplines and it really opens people's eyes to their own. If done well it can really consolidate their understanding of their profession. (Nancy, NE, E)

And ultimately the learning from interprofessional supervision was seen to benefit clients and service users:

I mean, I do take on board those different perspectives so it means my clients are getting a better deal because I'm aware of what else there is for them and also not just in terms of referring on, but you know thinking in terms of, I didn't have much social work perspective at all before I was in this job. (Nick, OT, R/E)

The benefits of interprofessional supervision for supervisees, as identified by the supervisors, were very similar to those highlighted by supervisees themselves: deeper enquiry and exploration of practice issues, development of interprofessional relationships, breaking down of practice silos and value for clients. “*So, all this discussion around richness, diversity, appreciative inquiry has got to be beneficial in the long run for the people that are using those services*” (Tony, SW, R). The supervisors also saw great value in the process for themselves both personally and professionally. Agnes (C,R) appreciated the opportunity to stretch across difference. “*So, to me that is quite a privilege. When am I ever going to get in a relationship with somebody who is really quite a long way away from where I normally sit and that is a real pleasure, I think*”. Leanne, (C/S, R) saw interprofessional supervision as a way to avoid becoming entrenched in the one profession:

It just extends my experience of meaning in the world as well and it is fascinating, you know. If you only supervise your own profession I think there is a potential to become stale and one of the things that I notice is that if you're heavily invested in a profession it comes to define also other aspects of your life and I don't want my work to also define the rest of myself. (Leanne, C/S, R)

Supervisors identified the mutuality of the learning. “*I found it hugely satisfying to supervise other disciplines because I think it broadens your own views. I've learned an enormous amount from listening to my supervisee*” (Sian, OT, R). For some supervisors interprofessional supervision provided a wealth of information about development and service delivery across sectors:

I love the diversity it keeps me connected to lots of different places and roles in the sector and it gives me such a fantastic overview of what's happening in health and social services that I probably wouldn't get if I was just in one. (Hazel, SW, R)

Several supervisors described interprofessional supervision with non-registered practitioners. These practitioners, who do not belong to a profession and frequently have no mandate from

their organisations (or interest groups) to have supervision, often arrive with no previous experience of supervision. Their supervisors therefore have a dual role of supervising across *practice*, since they do not have a profession, and also of teaching them about supervision and how to be a supervisee. For Hazel (SW, R) supervising this group of practitioners provided an avenue to promote supervision and its benefits:

It establishes supervision as a valuable process across a whole lot of disciplines. ... which also means that people are getting all of those benefits that come with supervision. So the more it sort of spreads ... the more it hopefully will be supported and better understood. (Hazel, SW, R).

Challenges.

To ensure that supervisees' clinical practice met their own professional standards and accountabilities was the most commonly identified challenge of interprofessional supervision. "*Limits - so it is making sure those people are accountable and safe back to their own discipline specific profession*" (Hazel, SW, R).

That being said, participants mitigated the limitations of this challenge by ensuring readily accessible arrangements were in place:

I therefore ultimately think it is quite straight forward. I can't expect my supervisor to sign off my competencies. I can't expect her to attest to my competence and my practice and I wouldn't. So you have to find someone else to do that. (Olive, OT, R/E)

As mentioned earlier, these arrangements included named persons, for example: managers, internal same-profession supervisors and/or professional or clinical leaders, with whom the practitioner had a specified agreement for clinical professional oversight. Alice (C/SW, R) offered cautionary advice "*As long as people aren't substituting professional [supervision] for really good clinical [supervision]*".

Also, as discussed earlier, participants believed that interprofessional supervision was not appropriate for students or for those who were new to the profession and that supervisors too needed to be experienced in supervision. For Sian (OT, R) the supervisor's competence needed to include the supervisor's knowledge of their own profession:

So, if the supervisor was quite new to the profession, possibly not. So, when I started supervising I would have had 8 or 9 years' experience. So I think you need to be reasonably experienced before you would delve into that. (Sian, OT, R)

This consideration of the supervisors' competence was developed by others. Olive (OT, R/E) believed that it was important for the supervisor not only to be knowledgeable, but also to be secure in their own professional identity "*And I guess if you're vulnerable in your profession then it would probably be quite unsafe as well*".

The difference in understanding between professions of what supervision encompassed was raised. "*I think different professions have different degrees of understanding of what supervision is, and that is just a current limitation*" (Cathy, SW, E). Similar concerns were voiced about supervisors' awareness of broader contextual issues, power and the status of different professions:

Where the supervisor doesn't appreciate the limitations, the difficulties, the issues of colonisation of another profession, the power issues involved in the two professions sitting together and talking about their work. (Isabelle, P, R)

And the other part of that for me that is really important is that I'm a psychologist and that is scary to people ... and it is a powerful position to have. And I think that people carry something? in their heads about it [and] that will get in the way of doing supervision. (Liz, P, R)

These concerns perhaps underpinned Olive's (OT, R/E) insistence that, in order to supervise someone from another profession, supervisors required training in supervision. "*So, my concerns would be quite simply if the other discipline wasn't a trained supervisor and they were supervising a different discipline*".

Situations where practitioners' professional practice was deemed lacking, or was under review, were similarly regarded as not suitable for interprofessional supervision. "*I think there might be a potential challenge in talking through someone that has been performance managed at the same time*" (Tony, SW, R). "*I think if it is performance management issues that again it would need to be someone from the same profession to be sure that the performance would be managed against the relevant standards*" (Elsie, N/C, R).

For Donna (C/SW, E) however it was very straight forward. "*I'm just going to go straight to the challenges first because I don't really think there are any [challenges]*".

Qualities.

The expert informants named a range of qualities which they believed to be necessary for those who participate in interprofessional supervision. Common to many responses was that

both supervisee and supervisor demonstrate: authenticity, openness, curiosity, empathy, respect, confidence, courage, honesty and humility:

I think openness and willingness to be open and honest about their practice and about what they don't know. I think being able to say as a supervisor or a supervisee 'I don't know' or 'I made a mistake' or 'I can't do that' or 'I can't help with that', you know, that kind of honesty is very important. (Bella, C, R)

Be willing to support, and honesty, and willingness to give constructive feedback if necessary. (Amy, MHN, R)

The participants' attitude towards their own profession and their confidence in themselves were considered important:

Maturity and experience and a depth of understanding of who they are in their profession to get the best out of it. (Liz, P, R)

Confidence in their wisdom to know their own disciplinary boundaries. (Helen, P, R)

The ability to not be defensive and precious about their own profession was raised:

But I think the big thing is not being defensive. Because if you are sitting and having to be defensive and justifying all the time about what you are doing, or trying to make sense of what someone is saying to you, in light of your understanding, then you are going to get lost. (Nancy, N/E, E)

They mustn't be wedded to their profession ... they have to take themselves out of the equation and be really focused on the person. They need to be clear about what they are doing and why they are doing it. (Liz, P, R)

So, the quality of not being precious, but also sharing their own passion and enthusiasm around your own profession as well. (Hazel, SW, R)

Other qualities included:

The willingness, and the ability, for both supervisors and supervisees to learn:

They have to be open to learning themselves. Like I learn from people that I supervise. (Liz, P, R)

Yeah I'm just really interested, I think. You have to be and probably open to being educated. (Agnes, C, R)

A valuing and deep respect all professions:

I think they have got to be genuinely interested in people and profession. They need to have quite a lot of self-awareness, self-control that they are different professions and no profession is better than any others. They are not there in that dominating role to sort of sell their professional opinion. (Ingrid, P, R)

I think ideally you need to value and deeply respect all the professions, you know, we are all fellow professionals here. (Alice, C/SW, R)

Knowledge, skills and expertise about supervision:

Be quite good at supervision. (Nick, OT, R/E)

Supervisees need to be prepared for their sessions. They need to have thought of something they want to take. Like I have to be accountable for my own practice and work. (Wendy, N, E)

I think you need to be qualified and know about the whole dynamics of supervision. (Ursula, Non, E)

An appreciation, openness and excitement about difference:

They need an open mind to the fact that it's an option and just a curiosity around a different way of looking at things and maybe doing things and maybe being able to challenge or question without judging, you know. (Linda, C, E)

Well, I think you have to really value what the diversity can bring I think, yeah, and not think that is the right way - counsellors do [it] the right way. (Ingrid, P, R)

The participants noted the need for an ability to sit with 'not knowing':

If people have a really good understanding of each other then they will feel less defensive and more able to communicate with each other and call on other people's expertise and recognise it is really important not to know everything. (Nancy, N/E, E)

Supervisors need to be non-judgemental and good listeners:

People need to feel you are not somebody who is going to be judging them, you know. (Ingrid, P, R)

From a supervisor perspective it is really that ability to bite your tongue and provide the space for that person to reflect rather than to feel that you have to jump in and educate them for everything that is a risk. (Sian, OT, R)

Accepting the person as they are right there. (Irene, C, R)

It was important for the supervisor and the supervisee to know themselves, their strengths and limitations and to acknowledge mistakes:

And I suppose probably you need to know who you are as a supervisor. You need to know who you are. So then you can hear who the other person is. (Helen, P, R)

This list of qualities and attributes, it is noted, has much in common with those lists presented in the broader supervision literature as being characteristic of, or as being required by, a 'good' supervisor (Carroll, 2014; Davys, 2005; Davys & Beddoe, 2010; Hawkins & Shohet, 2012; Kilminster, & Jolly, 2000). As such, it is suggested that interprofessional supervision, as presented here, is reflective of best supervision practice.

Advice.

Finally, the participants were asked what advice they would give to anyone who was contemplating an interprofessional supervision relationship. The advice provided addressed both supervisor and supervisee roles. For some the advice was encouraging:

Well, I would just be really clear about what you want to get out of it and be clear about the limitations of what you can do with each other. (Nick, OT, R/E)

I would encourage them but I would encourage them making sure that they had those two things. One they're trained and one they can view the world outside of being in. (Olive, OT, R/E)

Others were more robustly enthusiastic:

The only thing I would say is 'give it a go'. (Elsie, N/C, R)

Grab the opportunity. (Tony, SW, R)

My advice is 'do it'. (Agnes, C, R)

The advice summarises many of the issues raised in the interviews and incorporates many of the qualities identified by the participants as discussed earlier. A key message from the supervisees was 'to trust the process' "*Yeah, trust the process. That is one of the things I have learnt, just hang in there it works*" (Nancy, N/E, E). From the supervisors the advice was to 'trust yourself'. "*Trust yourself. I think it's probably about trusting, trust yourself*" (Helen, P, R).

The importance of supervision knowledge, expertise and training, contributing to a sound supervision process, identified throughout the interviews with the participants, were named as both necessary qualities and central pieces of advice. The responsibility of supervisees to make informed choices about their supervision was also highlighted:

Like, research the person and don't worry about what their profession is as long as they are qualified and they have got their supervision skills it doesn't matter what profession they are and you have to be a good match with the person and what they have to give has to be a good match. (Donna, C/SW, E)

Yeah, I would say 'look you can find out about them on paper which I think is always helpful because that will give you a little bit of information and I think you just need to go and have a session and then maybe a second session'. (Winnie, N, E)

Central to the advice was the importance of the supervision relationship and the personal qualities which each person needed to bring:

So, yeah, make sure that there's trust, there's honesty, you are prepared to ask questions, you are prepared to be humble, you are prepared to be courageous and do the work when you need to. (Leanne, C/S, R)

A key message which was threaded throughout these interviews concerned the quality and skills brought to that relationship by the supervisor. For some participants the supervisor's ability to supervise transcended any differences of profession. This is well summed up by Donna:

I'm firmly of the opinion that if you can supervise it doesn't matter what the person's profession is, especially if you're using [a] reflective learning model type thing. It is more about the way you facilitate because you are not being directive and you don't need to know everything about that profession. That's my opinion anyway. (Donna, C/SW, E)

A summary of the advice is presented in Table 6.7.

Table 6.7. Participants' Advice Phase Two.

Advice to Supervisors:	Advice to Supervisees:
<i>Trust yourself</i>	<i>Trust the process</i>
Know: What supervision is. Standards of practice.	Understand: What supervision is.
Negotiate: A clear agreement/contract.	Ensure: Clarity around limits and boundaries. That there is a clear agreement/contract. Accountability and access to profession knowledge and support
Be prepared to be: Challenged, Humble. Courageous. Willing to learn and to ask if you don't know.	Do: Your research and engage a supervisor who is: Qualified, Confident, Reliable, Empathic, Listens.
Make sure there is: Trust, Honesty, Genuine Interest, Transparency.	Be: Open and Honest.

At the conclusion of the interviews, the expert informants were invited (along with their supervision partner) to record a live supervision session. Six participants from phase two and their supervision partners consented to record a session. Chapter seven presents the findings from the analysis of those supervision sessions and matches them against the findings of this present chapter to produce a preliminary framework of interprofessional supervision.

Chapter 7: Interprofessional Supervision: Description

Interprofessional supervision ... creates rich opportunities for learning and practice development but at times equally large difficulties can occur due to differences of status, values, language, theoretical orientation and approaches to practice. Such a supervisory process can therefore be a personal and professional challenge, as it requires the supervisor to constantly learn about and adapt to the professional needs of the supervisee. It is also a challenge for the supervisee who needs to be open and allow another to learn about their profession and its associated values. (Townend, 2005, p. 588)

The third phase of this research invited participants (expert informants from phase two) to audio record a live supervision session. These recordings provided a window into everyday interprofessional supervision conversations and thereby provided an opportunity to observe and to describe, amongst other things, the skills, processes and structures which occurred in the interprofessional supervision exchange between these supervision pairs. For the purpose of discussion, in this chapter this process in the research has been termed ‘the Observation’ of interprofessional supervision. The exploration of the views and accounts of interprofessional supervision, gathered from the previous phase two, has been termed ‘the Report’.

Chapter seven is presented as two parts. Part one, the Observation, presents the analysis of the data from the audio recordings of the supervision sessions (phase three) These data have been organised according to three themes: relationship; professional practice; managing the difference. In part two, the Report, the findings of the phase two interviews, where participants explored their experiences of interprofessional supervision (chapter six), are reintroduced. These findings are then presented alongside the themes developed from the live interprofessional sessions observations of phase three. From an integration of these findings a framework of interprofessional supervision was constructed and is presented.

The Observation: Phase Three Recordings

Seven participants, three supervisors and four supervisees, from phase two, and their supervision partners, responded to the invitation to provide a digital audio recording of a live supervision session. As one supervisor and one supervisee were already in an interprofessional supervision arrangement, this meant that there were, in total, six supervision pairs. From these pairs, eight supervision sessions were recorded and presented

for analysis. Two pairs contributed recordings of two sessions while the other four pairs recorded one session each.

Demographics

The participants, supervisors and supervisees, represented a range of professions which included: corporate management, counselling, mental health nursing, non-registered profession, nursing, psychology and social work. Overall, they brought considerable experience to the supervision partnerships. Five of the supervisors¹⁰ had twenty or more years of experience in professional practice as did four of the supervisees. The remaining two supervisees had eleven and four years of practice experience respectively. All of the participants, supervisors and supervisees, had training in supervision. Four of the supervisees had a postgraduate qualification in supervision whilst one had completed two postgraduate supervision papers and another had undertaken short course training in supervision. The supervisors had a greater range of training which included two postgraduate qualifications, three certificates in supervision plus a range of workshops and non-assessed supervision courses.

Three of the supervisors had 15 or more years of experience in interprofessional supervision, one had ten and another had been involved in interprofessional supervision for six years. Only two of the supervisees, however, had significant experience in interprofessional supervision (19 and 15 years respectively) and, at the lower end, one supervisee reported that he had been engaged in interprofessional supervision for only four months. Interestingly, despite the range of experience, with one exception, all of these supervision relationships were relatively new, ranging between 18 and four months. These demographics are presented in Table 7.1.

¹⁰ For one supervisor, this information was missed in the early collection of demographic material. Subsequent follow up revealed that the participant had travelled overseas. An email message sent to the contact email address, which had been provided, received no response.

Table 7.1. Participants – Phase Three

Supervisor	Profession	Years of practice	Years of IPS	Supervision training	Supervisee	Profession	Years of Practice	Years of IPS	Supervision training	Length of time in supervision relationship
Amy	Mental Health Nursing	28	20	Certificate	Ursula	Non registered	25	15	Postgraduate Diploma	6 months
Liz	Psychology	33	30	Short courses, workshops	Yvonne	Counselling	29	19	Short courses, workshops	5 years
Tony	Social Work	20	6	Postgraduate Diploma	Leo	Counselling	4	4 months	2 Postgraduate Papers	4 months
Neil	Psychology	36	15	Certificate Courses	Jean	Social work	20	14 months	Postgraduate Certificate	4 months
Angela	Corporate Management (Counselling)	Information not available		Postgraduate Certificate	Molly	Nursing	11	8	Postgraduate Certificate	14 months
Nelly	Counselling Nursing	10 40	10	Certificate Courses	Winnie	Nursing	29	5	Postgraduate Certificate	18 months

As in chapter six, individual participants are identified by pseudonym and two sets of initials, one initial to identify profession and one to identify role. Table 6.5 Participant Profession and Role Identifiers explicates the different initials.

The Data

Thematic analysis was used to analyse the data collected from the eight recorded sessions. Three broad codes, *structure*, *content* and *process*, were constructed following initial reading of the transcripts of the recordings. From this grouping of the data three themes were built: relationship; professional practice; managing the difference. These themes, illustrated by examples from the participants' supervision conversations, are presented in this chapter.

Relationship

“Relationship factors continue to be where the action is, literally. Everything else resolves around it” (Bernard, 2006, p. 15).

Strong relationships were apparent between the participants of these interprofessional supervision partnerships. The supervisors' interactions with the supervisees were characterised by interest, curiosity and respect, while the supervisees demonstrated trusting engagement in the relationship. This trust was illustrated through the generosity and honesty with which the supervisees shared the issues they brought to supervision and their personal responses throughout the conversations. An underlying and explicit focus on supervisee self-care reinforced the supportive quality of these relationships. Whilst different processes were employed to set the agenda, in each of the supervision sessions the discussions were led by the supervisee.

The supervisors conveyed their interest, curiosity and respect for the supervisees through a range of supervision processes and skills. That they were focused on the supervisee, that they were listening attentively and that they were making sense of the information they heard, was demonstrated throughout the sessions by regular and detailed paraphrasing and summarising. Bond and Holland (2010) note that “summary can be experienced as supportive if it shows an attempt ... to really try to understand the supervisee's perspective, without adding [the supervisor's] interpretation or challenging them to look at [it] another way” (p. 162). Nelly summed up a discussion about Winnie's challenges dealing with a co-worker, while Tony summarised the behaviour of Leo's young client.

... and there are some areas, and this is perhaps the one you are pointing to, where you don't sense that perhaps she has a lot of confidence in being

able to manage conflict and to maintain more authority because you are saying if she were able to just set some boundaries it might be really reassuring and this just might settle. (Nelly, C, R)

I guess that is quite a natural thing, I suppose, when you have got a fairly, it sounds like a fairly astute 10-year-old girl. She knows what she can get away with and she is going to play some of those boundaries, having been quite experienced in the where now and knowing what the rules are. (Tony, SW, R)

Attentive to the supervisees' narrative, the supervisors were able to identify, and hold, a broad perspective on the topic in hand while connecting different aspects of the discussion. This tracking of supervisees' issues has been noted in other studies as being one measure of effective supervision (Kilminster & Jolly, 2000). The supervisors identified ideas and concerns, brought them together and connected themes, both from within the session and from previous supervision sessions.

I have just had a bit of a link in my mind, if we go back to the cultural responsiveness, you are bringing the context of that woman into the room by her starting with a prayer aren't you? (Liz, P, R)

And again, that is kind of following on from our last conversation because I know you were very concerned for him. (Amy, MHN, R)

I am reflecting on our conversations throughout this year and since you started in this role. You talked about this colleague right from the beginning and several times. So this- is this eating away at you so to speak? (Nelly, C, R)

...most of the things we've talked about actually today, there are some common themes running around through here, and some of them are just a dynamic that is carried over, I guess from what you talked about in terms of XXX and you in the past. (Angela, CM, R)

The supervisors conveyed positive regard and respect for the supervisees through generous and spontaneous affirmation which peppered the conversations.

That's a lovely way of talking about it. (Liz, P, R)

Fantastic, what a great question. (Angela, CM, R)

That is such a lovely quality. (Amy, MHN, R)

More critically, the supervisors were thoughtful about the supervisees' practice and provided unsolicited and specific positive feedback on the supervisees' work, values, attributes and achievements. This positive feedback stood alone as affirmation and was not connected to, or diluted by, comment on areas where improvement was needed. "Supervision is the place where work, effort and commitment can and should be recognised, validated and celebrated without being tied to conditions" (Davys & Beddoe, 2010, p. 144).

the way you approach your work is the bit that I admire the most, you know, like in terms of your drive to make it right and meaningful for people but also for yourself. (Liz, P, R)

You seem very calm, and your strengths come through. You know, you've got a real positive ...you shine a positive light on the situation don't you. You can see the positive. (Amy, MHN, R)

I mean, it sounds fantastic and, also just from hearing you talk, you know, I'm really hearing almost an evolvment of coming out of where you've been in this role. (Angela, CM, R)

You've got a real sense of confidence – 'actually this can be easily managed' - and that means you are kind of able to. (Nelly, C, R)

In these supervision sessions the supervisees demonstrated that they were at ease within, and trusting of, the supervision relationship. The working alliance, or relationship between a supervisor and supervisee, as noted by Bond and Holland (2010):

aims towards providing a secure psychological base for the supervisee within which to feel safe enough to grasp the nettle of accepting support for vulnerabilities, consider challenges to actions, values and attitudes, and reflect in depth on their own clinical practice and their own part in it. (p. 122)

This was evidenced in the recorded sessions by the manner in which the supervisees shared their agendas and issues with openness and candour, and their willingness to disclose anxieties, vulnerability, uncertainty and, on occasion, strong emotion.

I guess the biggest part is, I don't actually think I've got their respect anymore. (Molly, N, E)

I think I feel a level of shame and maybe guilt ... I think I should be more culturally aware. (Yvonne, C, E)

My rational mind tells me that. Sort of critical thinking or, I mean, there's no evidence that they are thinking that. It is some of my own twisted thinking. (Ursula, Non, E)

So, that just caused this huge tension and it made me feel very upset and I realised that one of the reasons I felt very upset ... I find confrontation really hard ... and XXX has been allowed to get away with a shit load of stuff because we are not a confrontational bunch. (Winnie, N, E)

Supervisees were able to share and celebrate good work:

.... and then there was that couple that sent me a photo of them, you know a happy pose of them happy and said ... 'don't know if you remember us but you saved our relationship, we just want to let you know we are still going strong, and look at us, and this wouldn't be us if it wasn't for you.' Which of course is rubbish but it feels nice. (Yvonne, C, E)

Finally, supervisee wellbeing, a personal/professional focus in the supervision relationships, was clearly at the forefront for these supervisors and supervisees. Health, stress and the on-going self-care of supervisees was discussed by five of the six supervision pairs. For one partnership it was a fixed agenda item:

And we will have a usual standing item which is just your general wellbeing and how things are going for you. (Neil, P, R)

At other times supervisee well-being was considered in relation to the impact of health or stress on the supervisee, on the current work and on planning for future practice.

The other question that is sitting in my mind is around the impact on you. You know if we go back to what we were talking about in the beginning, about having XXX and your own health... (Liz, P, R)

How are you looking after yourself in this uncomfortable process? (Nelly, C, R)

Yeah, but it is sort of that juggle between being conscientious at work and having to plan strategically when I'm not probably going to be here, you know, doing my planning work. (Ursula, Non, E)

Professional Practice

“Supervision is to assist you in becoming a more effective professional in all ways!” (Carroll & Gilbert, 2011, p. 52).

What to bring to supervision is a question perpetually raised by supervisees regardless of profession, practice context or practice experience. Bond and Holland (2010) identify four areas which can be reviewed in order to raise topics for supervision: care of a specific patient/client; areas of responsibility of your work/caseload; stress/pressures having an

influence on your work; your development within your work (p. 129). Hawkins and Shoheit’s (2012) seven eyed model of supervision provides additional areas for focus by including the different relationships within professional work and the wider socio–political and economic context of practice.

The supervisees, in the eight supervision sessions observed, covered much of this territory. As mentioned earlier, supervisee self-care featured in six of the eight sessions and, as such, was the most common topic to be discussed, followed closely by structural, functional and relational topics such as organisational and professional role and professional relationships. Three sessions discussed specific clinical casework, and theory was identified or named in four sessions. Less frequently discussed were ethics and professional difference and one supervisee chose to use the supervision session to review her practice during the previous year. The topics and the frequency with which there were discussed are summarised in Table 7.2.

Table 7.2. Content of Supervision Sessions Phase Three

Topic	Addressed in sessions (n = 8)
Self-care	6
Organisational role	5
Professional relationship	5
Professional role	5
Organisation systems and process	4
Personal professional development	4
Theory	4
Case work	3
Ethics	2
Professional difference	2
Review of practice overview	1

The focus within the supervision sessions, however, regardless of the topic being discussed, was on the development of the supervisees’ professional practice. Whilst the discussions were led by the supervisees, the supervisors contributed to and deepened the discussion through a range of interventions and processes.

Ideas and actions which the supervisees had voiced and described were heard, reinforced and encouraged. Bond and Holland (2010) note that when such observations are voiced by the supervisor it can “feel especially supportive” for the supervisee (p. 162).

And sometimes, like you say, you step back and pass back, you know, you don’t have to come up with a solution or you don’t have to give the answer.

You just have to facilitate that process happening and put supporting boundaries on the outside. (Angela, CM, R)

Good, you've got 20 hours a week and you've worked it out what projects you want to focus on, you've worked that out for yourself. You've worked it out with your managers. So that is kind of quite clear isn't it? (Amy, MHN, R)

So, I like your idea, actually, of a case consult about, well where to from here, because I agree it sounds like another intake would be really ... (Tony, SW, R)

So you'll be setting appropriate boundaries with your colleagues and if there is something that you are not happy about you will voice that. (Nelly, C, R)

That is a very good point. Yeah absolutely I think that makes a lot of sense. (Neil, P, R)

The supervisees' ideas and actions were stretched and developed by the supervisors' employment of a range of interventions. Some of these interventions are illustrated below.

Interpretation:

It's a double edged sword. On the one hand you haven't had the support at a time when you felt you could have done with it, but not having the support you've been able to do all this stuff. (Amy, MHN, R)

Coaching:

You and XXX would have to be clear what you are going into first, but you work that out with her - what your decision is. But from your role in the leadership, that would definitely be the way to use those skills. (Angela, CM, R)

Direct advice:

Maybe, if I could make a suggestion. Is this something to do with a conversation, not with clients but with a Māori counsellor or having access to a conversation with somebody who has expertise? (Liz, P, R)

Have you thought about leaving a message on your work phone? (Amy, MHN, R)

Sharing of practice knowledge and wisdom:

Because certainly, in terms of managing these high complex multiple needs young people, and certainly best practice kind of tells us, rather than just everybody doing their own little thing, the more we can coordinate and get multi-agency plans together usually the better chance you have of managing things. (Neil, P, R)

At times, the supervisors provoked new ideas and strategies through questions and sharing their own reflection:

and the reason I wondered that is - I wonder if you are describing a confusion in the system? (Nelly, C, R)

Do you need to discuss with XXX to clarify that for yourself? So it doesn't sit hanging when you go into the further hui... you don't sit [with] 'should or shouldn't'. (Angela, CM, R)

So maybe sometimes just a little fine tuning of things - how they respond to things. It sounds like they are doing a lot of things right and have a good positive focus. (Neil, P, R)

So, the goal has been around developing that personal space and respecting others. Has there been a goal around the other sorts of boundaries that you are talking about there? (Tony, SW, R)

Managing the Difference

The difference of profession held by supervisors and supervisees, with one exception, was not discussed in the recorded sessions. The exception was a supervisee who, when reviewing her year, offered spontaneous feedback to the supervisor about the benefits of the supervisor's different professional perspective:

I do want to thank you for your part in my practice because you do ask some really good questions, you are really good at sharing resources and networks, you know, because your networks are a bit different. (Yvonne, C, E)

Yvonne's feedback names the core skill as "really good questions", which was employed by all of the supervisors in these interprofessional supervision sessions. As noted earlier in this chapter, the supervision discussions were led by the supervisees. The supervisors employed a wide range of questions which drew relevant knowledge and information from the supervisees and this was in turn incorporated and considered within the supervision session. The questions elicited specific information, explored practice, promoted reflection, deepened reflection and shaped future action. By ensuring that information was clear and shared the

questions lessened the likelihood of assumptions being made. There was no evidence of assumptions in the recorded discussions.

Most commonly, the information, which supervisors requested from the supervisees, explained or clarified organisational policy, process or structure:

I just wonder, as well as implementing the policy that penalises the staff for this, what they implemented. Did they implement anything at the same time that also addresses that this is going on in the organisation, a supportive element to the policy? (Angela, CM, R)

So, there's lots of issues, lots of agencies, is there any coordination of everybody? (Neil, P, R)

So, who do you take this to within the organisation? XXX is of the mind-set that she has dealt with it in that moment. (Angela, CM, R)

The supervisee's role and responsibilities within the organisation were explored and, at times, connections were made between these roles and professional skills and knowledge:

And are you the one that would be delivering that news to them and talking through that with that new strike process? (Angela, CM, R)

So you are the kind of coordinator? (Amy, MHN, R)

Maybe all of those - the instigator, and tied up with that is the spokesperson, but you are moving to potentially a facilitatory role, a bit of a teaching role and then what else is in there? What resources, what skills and qualities might you be drawing on to make your point - to make sure that this is worked through. (Nelly, C, R)

Specific questions were asked which explored the supervisees' practice and expanded the thinking and content of that practice. These questions focused on areas such as skills and interventions, resources, and patterns of work:

So, what strategies have you and the team been using with her so far around her developing her personal space and respecting other's personal space? (Tony, SW, R)

So that is his unsafe behaviour. What does his progressive behaviour look like? (Neil, P, R)

So, how can you position yourself and give her a message of what you need? (Nelly, C, R)

So, how did it go involving XXX because that's the first time you've done that isn't it? (Amy, MHN, R)

What might be some of the pitfalls with that, do you think, in those relationships with other professionals? (Tony, SW, R)

The most frequent questions, however, were those which promoted reflection and those which deepened the supervisees' reflection into a critical examination of practice, self, motivation and personal connection. The following brief interactions illustrate these exchanges where the supervisor, noticing and highlighting a particular aspect of the supervisee's narrative, poses a question which in turn extends the supervisee's thoughts and ideas on that point:

Supervisor: *Annoying for yourself or annoying because you end up in a situation where you feel overwhelmed having to make a decision. (Angela, CM, R).*

Supervisee response: *The annoying bit is more 'I can always make better decisions'. When I come to think about it, I know that, but I guess I don't have it in my head as my evidence for making that decision. (Molly, N, E)*

Supervisor: *It would be interesting to have noticed whether he would pick it up or not. What stopped you mentioning it to him? (Liz, P, R).*

Supervisee response: *...and so I thought, okay, I am not going to introduce anything else to him, but, you know, I might be doing him a disservice in that as well. (Yvonne, C, E)*

Supervisor: *So, that might be something to think about because it is harder to say no to people, rather people in our working lives. It's quite normal to get an answer you know. (Amy, MHN, R)*

Supervisee response: *Absolutely, I just fell into it again. So that is something to think about and prevent with phone and out of office because I don't know how that is going to look. (Ursula, Non, E)*

Supervisor: *There are two perspectives, I'm thinking. One of them, because you said from a collegial point of view, but you also pointed to the fact that she is your team leader. So, how about you consider how you are placing yourself. (Nelly, C, R)*

Supervisee response: *I know, you see that's the one thing that does concern me is that I am starting to say 'look you need to do this'. (Winnie, N, E)*

The questions and reflection moved into future action:

So, what are you thinking, where do you think we should go with it? (Neil, P, R)

How do you make it work next time? (Angela, CM, R)

And how would you frame it up, how would you give it some structure, some shape so that person knew what your intention was. ... and if you were going to do that what might you say. (Nelly, C, R)

Summary

In summary, these supervision sessions built on an understanding that the supervisor and supervisee did not share a common profession, demonstrated how professional difference can be navigated. A strong professional supervision relationship, an understanding of the supervision process and a willingness to engage in that process were evident. The material brought to supervision, though weighted towards broader organisational and relationship issues, nevertheless covered a range of topics, which included specific casework, and paid particular attention to supervisee self-care. The focus of the sessions was on practice development, where exploration, reflection, deeper critical meaning and understanding were elicited through a wide selection of open questions.

The Report: Phase Two Interviews

The previous chapter, chapter six, detailed conversations with 29 expert informants, all currently engaged in interprofessional supervision, who described their experiences and views about this process (phase two). Three themes were constructed from those interviews: choice and the development of the professional self; interprofessional supervision: a structured process; diversity as a vehicle for learning. There was an underlying proposition that supervision was a professional practice in its own right and that, as such, it transcended individual and separate professions. The accommodation and management of difference were considered to be essential elements of supervision practice.

The characteristics of interprofessional supervision, as reported by the participants of phase two, were presented in summary in Table 6.6. This table is reproduced here and, where relevant, the characteristics have been matched to the data which have been identified in the recorded supervision sessions (phase three). See Table 7.3.

Table 7.3. Characteristics of Interprofessional Supervision – Phases Two and Three

	Interprofessional supervision Reported	Interprofessional supervision Observed
Characteristic	<i>Phase two interviews</i>	<i>Phase three live session recordings</i>
Training	Supervision training and knowledge are essential for supervisors and preferable for supervisees.	The supervisors all had some form of supervision training, ranging from postgraduate qualifications to supervision workshops and non-assessed courses. All of the supervisees had post-graduate training and/or qualifications in supervision.
Experience	Interprofessional supervision is best accessed by practitioners (supervisees) who possess expertise, practice competence and a well-developed professional identity.	A majority (four) of the supervisees had 20 or more year of experience, one had 11 years and one 4 years of experience.
Choice	The ability, or the freedom, to choose a supervision partner and whether to engage in that particular supervision relationship is of particular importance.	Not covered in the recorded sessions.
Initial Meeting	The importance of an initial meeting between the supervisor and the supervisee to determine whether the relationship has the potential to meet the supervisee’s needs and for both parties to determine whether there is an appropriate ‘fit’ of expectations, skills, values and personality.	Not covered in the recorded sessions.
The Supervision Agreement/ Contract	The expectations and parameters of supervision are negotiated and the limitations and boundaries of knowledge are disclosed.	Not discussed.
Difference	Commonly identified, and strategies developed to manage it, when supervision agreements/contracts are set in place at the beginning of the supervision relationship.	Difference was only mentioned (as an asset) by one supervisee when reviewing her year of practice and supervision. Otherwise, difference of profession between supervisor and supervisee was not named and did not feature in conversations.
Professional Accountability	The supervisee’s accountability to his or her own profession is acknowledged and additional relationships and/or people are identified to ensure that this responsibility is addressed and that the supervisee has appropriate	Not addressed explicitly in sessions. Organisational lines of accountability were mentioned.

	access to profession specific knowledge. This is commonly discussed in contracting session.	
Supervisor Role Clarity	Interprofessional supervision has a <i>supervision informed</i> focus rather than a <i>discipline informed</i> focus.	Blurring of focus not evident.
The Supervision Process	To create a space, or a learning place, where the supervisee could safely and honestly reflect.	Supervisees shared a range of emotions and demonstrated open and honest communication and thoughtful reflection.
Trust and Respect	Interprofessional supervision is based on a trusting and respectful relationship.	The supervision conversations demonstrated a basis of trust.
Support	Supervisors took a supportive role in interprofessional supervision.	Supervisors demonstrated strong and supportive relational behaviour.
Skills and Interventions	Topics for discussion were led by the supervisee and facilitated by the supervisor through open questions, active listening and reflective enquiry.	The supervisees led the discussions and the supervisors demonstrated attentive listening and asked a wide range of questions.
Professional development and growth	Professional development and growth were considered to be the central aims of interprofessional supervision. The main focus on interprofessional supervision was on the processes, structures and systems of practice rather than the details of clinical practice this included: the supervisees' self-management, self-care, relationship-management and professional identity.	The focus of the recorded sessions was on practice development. Supervisee self-care was specifically addressed by five of the six pairs. Whilst the most common focus was on organisational structure and process, and on role and professional relationship, the agendas were broad and three of the sessions considered clinical practice.
Functions of Supervision	A central characteristic of interprofessional supervision was that the responsibility for ensuring that the various functions of supervision were addressed was shared between the two participants, supervisor and supervisee.	This was not explicit in the recorded sessions but was evident in the range of topics discussed– professional and organisational responsibility, professional development and learning, and accessing support and resourcing.
Supervision portfolios	Practitioners' access different forms of supervision and other professional relationships were considered to be important.	Not discussed.
Interprofessional Conversations	The differences in profession between supervisor and supervisee assisted them to avoid the trap of making assumptions.	No assumptions apparent. On occasion one or other of the supervision partners requested clarification of meaning.

Professional Identity	Interprofessional supervision further developed a sense of understanding and appreciation of participants' own professions.	Professional identity was not explicitly referred to in the sessions.
Supervision as a professional practice	Supervision was considered as a professional practice in its own right which transcends individual and separate professions	Characteristics included: initial engagement in the session, agenda setting, follow up on previous sessions, supervisee focus and supervisee led, open enquiry and reflection, identification of future action.

When considering Table 7.3 it can be seen that there is congruence between practice of interprofessional supervision as both reported and observed. It is noted that the phase two interviews covered territory which was not accessed in the live sessions and provided a broader overview of interprofessional supervision and its processes. For example, the element of choice and the establishment of 'fit' were not addressed in the recorded sessions. The setting of the supervision agreement/contract, where many important issues are negotiated and determined, is similarly mentioned on several occasions in the phase two interviews but is absent in the live session recordings. The live sessions capture the conversations of established supervision relationships, where the agreement/contract will have already been negotiated and, unless there was a particular issue it is unlikely that the contracting conversations would be revisited.

Nevertheless, when comparing the reports of the dynamics of the interprofessional supervision session (phase two) with the observed behaviour (phase three) there is considerable overlap. The observed interventions and exchanges in phase three illustrate the phase two descriptions of the supervision conversations and support the reports that interprofessional supervision is a supervisee led process which is facilitated by the supervisor within a relationship founded on trust and respect.

Interestingly, the management of difference, which was well articulated and considered in the phase two interviews, was not immediately evident in the live sessions. As described in phase two, difference was acknowledged, addressed and strategies for its management were typically agreed in the early contracting session(s) but, as mentioned above, the live sessions recorded supervision exchanges which had moved beyond those early stages. What was evident in the recorded sessions was the focus on the supervisee as the central participant and narrator of the supervision process and the employment, by the supervisors, of open question enquiry. "The art of open question enquiry requires the supervisor to have the

capacity for meaningful engagement in the supervision relationship, humility to put self-preoccupation aside and listen, curiosity and a versatile framework of questions” (Davys & Beddoe, 2010, p. 134) . Through this process of open question enquiry matters of difference, or areas where the supervisor had no particular knowledge, were explored as a matter of course, rather than as a matter of surprise or concern. Difference in these sessions did not need to be highlighted because assumptions were not made.

It is, however, important to acknowledge that the eight sessions analysed here are a very small sample of interprofessional supervision exchanges. They cannot be seen to do any more than they were intended to which was to provide a window (indeed a very small window) into interprofessional supervision conversations. The selection criteria of this study must also be acknowledged. This has been discussed in chapter four and will be further addressed in chapter nine.

A Framework

From the analysis of the explorations of phase two, and of the descriptions of phase three, a framework of interprofessional supervision was constructed. Five key characteristics were identified which included: underlying propositions, qualities brought by the participants, the development of the supervision relationship, the structure and process of the supervision session, and access to adjunctive same-profession relationships (supervision portfolios). The framework is presented below, where it has been supported and illustrated through examples from the data. A modified version of this framework, which included a diagrammatic representation (appendix 8) and a brief video, were presented to participants of phase four who were invited to review the framework and to provide comment and critique. This feedback and critique are presented in chapter eight.

Characteristic 1:

The framework is underpinned by two propositions:

1. That supervision training and knowledge are essential for supervisors and are preferable for supervisees.
2. That interprofessional supervision is most often accessed by, most relevant to and appropriate for, practitioners (supervisees) who are experienced practitioners.

Characteristic 2:

A number of qualities are identified as being important for both supervisors and supervisees to demonstrate which include: authenticity, openness, curiosity, empathy, respect, confidence, courage, humility and a willingness to learn.

For example:

An appreciation, excitement and openness regarding difference:

well, I think you have to really value what the diversity can bring and not think that there is the right way. (Supervisor)

I'm not into 'you're this and I'm that'. I'm into 'we share common ground and if we don't, you know, how exciting is that - let's explore'. (Supervisee)

The courage and confidence to be able to sit with 'not knowing':

If people have a really good understanding of each other, then they will feel less defensive and more able to communicate with each other, and call on other people's expertise, and recognise it is really important not to know everything. (Supervisee)

Confidence in themselves as practitioners within their own profession, knowledge of themselves, their strengths and limitations and the ability to acknowledge mistakes:

Maturity and experience and a depth of understanding of who they are in their profession. (Supervisor)

And I suppose probably you need to know who you are as a supervisor, you need to know who you are. So then you can hear who the other person is. (Supervisor)

I think being able to say as a supervisor, or a supervisee, "I don't know" or "I made a mistake" or "I can't do that" or "I can't help with that", you know, that kind of honesty is very important. (Supervisor)

The ability and willingness, of both parties, to learn:

It's that genuine - are you actually interested and, do you want to learn about it, and journey with people around it and then if you do have that and you accept yourself as you are and that you are going to make mistakes along the way and you will learn with them, yeah that is all I can really say. (Supervisor)

Characteristic 3:

The relationship is central to interprofessional supervision and three factors contribute to the development of this relationship.

Choice: this includes the ability, or the freedom, for both the supervisor and the supervisee to choose whether to engage in a particular supervision relationship:

I guess I deliberately did choose her because she wasn't a nurse.
(Supervisee)

Fit: this is usually determined in an initial meeting between the supervisor and the supervisee. Does the relationship have the potential to meet the supervisee's needs and do both parties believe that there is an appropriate 'fit' of expectations, skills, values and personality?

Part of that is a gut feeling, and honesty is a large part of that and rapport. ...There's the personal, the fit of the person and then there's the fit of the profession and skill requirements to my background. So when it comes to the fit of the person to person there's the need to feel trust in both directions. I can trust that person and they can trust me, would be number one. (Supervisor)

Negotiation: the supervision agreement/contract and the discussion, the disclosure and the negotiation which accompanied the establishment of the contract are seen as critical. The contracting process acknowledges and clarifies the expectations and parameters of the supervision, the limitations and boundaries of knowledge, difference and the strategies to address difference, and the supervisee's accountability to his or her own profession and clinical practice.

No, I think as long as people have a contract and they are clear what they are getting involved in, and the knowledge of each party and the limitation of the knowledge of each party, then I think it is quite clear. (Supervisee)

Characteristic 4:

The interprofessional supervision session itself is identified as having three components.

The structure: interprofessional supervision creates a space, or a learning place, where supervisees can safely and honestly reflect and where their professional development and professional growth are supported. There is a focus on the processes of practice, the structures and systems of practice, the supervisees' self-management, self-care, relationship-management and professional identity. Topics for discussion are led by the supervisee and

facilitated by the supervisor. And, very importantly, supervision is driven through a knowledge of *supervision practice* as opposed to *profession specific practice*:

So, I think there is the massive risk that if there are professions that aren't trained [in supervision] then they are going to be expecting clinical practice based on their paradigm and it destabilises a different profession.
(Supervisor)

The process: the responsibility, to ensure that relevant professional accountability and professional responsibilities are covered for the supervisee, is *shared* between supervisor and supervisee. The trap, and the danger, of making assumptions is noted and managed by maintaining curiosity and openness, tolerating 'not knowing' and asking a range of questions.

It was actually helpful because the questions that came were not from a knowing of 'oh this is what you would do', but rather 'well that is interesting, why is that?' (Supervisee)

The skills: a range of skills and interventions are used by supervisors with particular emphasis on: open reflective enquiry, challenge, attentive listening, paraphrasing, summarising, affirmation, feedback.

Characteristic 5:

Finally, supervision portfolios: many supervisees also access alternative forms of professional relationships, which address areas not covered in interprofessional supervision. In particular, these additional relationships typically include supervision, consultation or accountability for profession-specific clinical practice.

The framework for interprofessional supervision, developed through the integration of the findings of phase two and phase three, and included here in this chapter, was presented to participants of phase two for critique. This fourth phase of the research is described and discussed in the following chapter.

Chapter 8: Interprofessional Supervision: A Map

The pieces that most resonated for me, regarding the distinctiveness of interprofessional supervision as opposed to same-profession, were that it is a relationship that demands mutual learning and requires the supervisor to sincerely believe that there is reciprocal learning to be had and is required from the supervision relationship. The willingness to learn and genuine curiosity and belief that there is knowledge and learning from another profession to enhance one's own practice is paramount. (Alice C/SW, R/E)

In the fourth, and final, phase of this research participants from phase two were invited to review a framework of interprofessional supervision which had been created from the data gathered in the earlier phases, two and three. Participants were asked to consider the framework and to provide feedback and comment. Chapter eight reports and discusses the responses of those participants and, based on this collaboration and feedback, presents a Map for Interprofessional Supervision.

A change in data collection, detailed in chapter four, shifted the collection method of phase four from focus groups to electronic member reflection. Invitations were extended, through email, to participants from phase two of the research (which included those who had contributed to phase three) inviting them to collaborate with the researcher to build a map of interprofessional supervision. The participants were requested to provide written feedback and comment on the interprofessional supervision framework,¹¹ which had been developed following phase three of the research. The feedback and critique were guided by four questions which were included with the material sent to the participants. The material and information (see appendix 8) were disseminated through email and a video (accessed through the University of Auckland Drop Box) to those who agreed to participate. Responses were returned through email and email attachment.

Twenty nine invitations were sent to the participants of phase two and twenty three of these invitees completed this phase of the research. This group comprised eleven supervisors, nine supervisees and three who contributed as both a supervisor and as a supervisee. A breakdown of the professions of the participants is presented in Table 8.1.

¹¹ This framework included a diagrammatic representation of the framework which some participants referred to in their feedback as *the diagram* or *the model*

Table 8.1. Demographics Phase Four Participants

Supervisors (n =11)	n	Supervisees (n = 9)	n	Supervisor and supervisee (n=3)	n
Counsellor	2	Counsellor	1	Counsellor/social worker	1
Counsellor/social worker/teacher/supervisor	1	Counsellor/social worker	1	Occupational Therapist	1
Counsellor/supervisor	1	Non-regulated workforce	1	Psychologist	1
Mental Health Nurse	1	Nurse	3		
Nurse/counsellor	1	Nurse educator	1		
Occupational Therapist	1	Social Worker	2		
Psychologist	2				
Social Worker	2				

The participants' feedback and comments were thoughtful and contributed useful perspectives to pressure-test the framework presented. Although not all participants responded to each specific question, some choosing to make more generalised comment, their responses and critique were organised, and will be reported in this chapter, according to the four questions posed. Additional and general comments were considered thematically and matched to the four questions. After consideration of the responses to the questions, this chapter concludes with a discussion of the main points of critique made by the participants and describes how these points have contributed to a final map of interprofessional supervision. As in previous chapters, the participants are identified by pseudonyms and two sets of initials, one to identify profession and one to identify role. See Table 6.5 to explicate the different initials.

How Well does the Framework Reflect your Understanding and Practice of Interprofessional Supervision?

Participant responses indicated that the framework was a good representation of their understanding of the practice of interprofessional supervision. Of the eighteen responses to this question, sixteen were specific in their affirmation of the framework:

The framework is a comprehensive representation of the way I understand interprofessional supervision. (Linda, C, E)

I really like the visual depiction of the framework which I think is a very good fit to my approach to inter-professional (sic) supervision. I think it captures the underlying propositions, skills and experience required to effectively engage cross discipline. (Sian, OT, R)

Features of the framework which were considered to be of particular relevance were highlighted. The focus of interprofessional supervision on the processes and practice of supervision, as opposed to the processes and practice of the profession, was appreciated and validated by participants:

... the distinction between supervision practice as opposed to profession specific practice. This clarifies nicely the issue of maintaining independence in one's practice and helps prevent the danger of 'colonising' another's practice. (Isabelle, P, R)

Jean, a supervisee, reinforces this through reflection on past difficulties when “*supervision is driven by profession specific practice not supervision practice. This has made my supervisory relationship difficult with one particular supervisor in the past*” (Jean, SW, E).

The two propositions which were named as underpinning the framework drew comment. The first proposition states *that supervision training and knowledge are essential for supervisors and are preferable for supervisees*. Participants agreed that it was very important for supervisors to have training in supervision but, more particularly, they considered that supervisees in interprofessional supervision arrangements should also have knowledge and experience in supervision. Examples were given of the difficulties when supervisees did not have this knowledge:

I particularly liked the point that supervision seems to flow better when both parties have an understanding of the supervision process and some training in supervision. As a supervisor I find sessions are much harder work when the supervisee does not have a good sense of what supervision is about and/or is not motivated to treat supervision as a learning opportunity. (Olwyn, P, R/E)

Donna expressed her personal frustration about working with supervisors who had no supervision training:

I have a continued frustration that none of the very lovely and experienced supervisors I have personally encountered have ever done more than incorporate the priority setting part of the [XXX] model after I've introduced it to them, and I wish they would. I think there should be wider training available for the model for existing supervisors, and so I would suggest that training for any potential new model of supervision, and the model mentioned above, be disseminated through relevant professional bodies as workshops. (Donna, C/SW, E)

The second underpinning proposition states that interprofessional supervision is most often accessed by, most relevant to, and appropriate for, practitioners (supervisees) who are experienced practitioners.

Responses to this proposition varied. Some participants agreed that this was their experience of interprofessional supervision. *“It reflects my understanding very well, in particular its use by experienced rather than new practitioners”* (Elsie, N, R). Others, whilst agreeing with the proposition, felt that it did not accord with the reality of interprofessional supervision practice experienced by many professional practitioners. Newness to the profession, they observed, often included a lack of experience and knowledge about supervision. *“I am not sure that some supervisees have had enough experience of what they are doing and how to use supervision before interprofessional supervision being an option presented to them”*. (Tony, SW, R)

Leanne spoke of her experience where it was accepted, and often expected, that new practitioners access interprofessional supervision:

This is not the case in my experience. I have young practitioners, both in terms of age and experience, who are expected to participate in interdisciplinary teams and interprofessional supervision (peer and otherwise). It is becoming the norm rather than the exception left only to the experienced. (Leanne, C/S, R)

The centrality of the supervision relationship, where choice, establishing fit, and negotiating the agreement/contract are considered important, drew comment:

It is helpful that the supervision relationship is centre of the framework and a key element throughout the description of the other elements. (Sian, OT, R)

I’m a big fan of the core conditions and the supervision relationship being the most important criteria for successful supervision, so in that way this framework fits very well for me. I’d rather see someone who can work effectively with me than someone who knows everything about my profession, but who is a poor personal fit for me. (Donna, C/SW, E)

Agnes, commenting on ‘fit’, demonstrated the courage and transparency often required in supervision conversations and also highlighted the point that professional difference is but one of many differences which need to be considered in these professional relationships:

One of the frustrating things about “fit” is that I feel it is necessary to declare my sexuality and sometimes my religious affiliation to a new

supervisee. This is, of course, not necessary for heterosexual supervisors. I once did not do this with a Catholic supervisee from a different profession who had a strict family belief system and I felt limited and slightly anxious throughout the relationship. (Agnes, C, R)

As alluded to earlier, questions were raised as to whether all interprofessional supervision relationships were based on choice. “*Choice is important in establishing these relationships - my wondering is whether this always occurs for supervisees? Some of my interprofessional supervision arrangements have started with the supervisee being instructed by a manager to see me*” (Tony, SW, R).

Elsie’s comment on the contracting process was typical. “[*T*]he importance of a robust contracting process so expectations are clarified” (Elsie, N/C, R).

For Alice, the description of the interprofessional session resonated:

The piece of your model I really liked ... where you talked about it being a learning space, reflective space, processes and structures and systems etc. That was a really useful capture of what interprofessional supervision offers and looks like. (Alice C/SW, R/E)

Finally, the place of additional or adjunctive professional relationships to support, and provide accountability to supervisees in their professional specific work, was noted and affirmed:

... supervision portfolios, I think this is the most important part of the interprofessional supervision relationship, however, and is a requirement that cannot be overlooked. (Leanne, C/S, R)

In particular, complimenting interprofessional supervision with discipline specific supervision is a key issue in my experience. (Hazel, SW, R)

What is Missing? and What would you like to Remove or Modify?

The second and third questions asked participants what is missing and what they would like to modify in the framework presented. The responses to these two questions overlapped to an extent that made it difficult to usefully separate them so they will be considered here together. The comments covered a range of issues, which have been clustered under subheadings. Some of the comments, such as those which name the benefits of interprofessional supervision, extend beyond the given brief to critique the framework, and relate to discussion and findings presented elsewhere in this thesis. They are nevertheless

reported here as feedback which supports the development of this interprofessional framework.

Words, descriptors and the framework.

Participants identified missing terms, requested definitions, questioned the use (or requested removal) of certain words, and suggested rearranging different components within the framework:

Did you put the word collaborative into your framework? I know you have used the word negotiated. Collaboration seems a significant concept in professional supervision. (Bella, C,R)

Does the term 'interprofessional' need to be clarified? (Winnie, N, E)

Is it possible in your definition to talk about interprofessional supervision being for experienced practitioners and professionals? The word 'a practitioner' implies the helping professions or private practitioners only and I personally believe interprofessional supervision is helpful for anyone working with people including HR professionals, educators, managers etc and others within organisations. (Bella, C, R)

I think the "underlying propositions" box really is the circle rather than a box. That way it provides the context for a successful inter-professional relationship. (Sian, OT, R)

Portfolio.

Supervision portfolios, identified earlier by participants as being valuable and important to include in an interprofessional supervision framework, were questioned by others. There was some puzzlement about what this term meant, whether it was a best term and how professional accountability could be assured:

With respect to supervision portfolios, I am not entirely sure of what you mean here, except to say that we sit within a nest of supportive collegial relationships that have different functions which all may intersect and relate to the three functions of supervision in some way – formative, normative, restorative. (Isabelle, P, R)

How does the supervisee ensure accountability to their profession and use of other modes of supervision? How would the interprofessional supervisor ensure this/clarify this in the contract? (Tony, SW, R)

The reality of fiscal and resource constraint along with the influence of management, shaped by their understanding and experience of supervision, were introduced by Donna:

While I think it's really important for any supervisee to access support, new skills and knowledge from a variety of other sources, practitioner and/or agency constraints around cost are likely to preclude any other forms of formal supervision, (cultural, profession specific etc,) other than line management, which depending on your line manager and their experience and competence, may or may not be adequate to cover the gaps. (Donna, C/SW, E)

Winnie did not think that the supervision portfolio was positioned appropriately in the framework. “*Supervision portfolio: I don't like where it sits on the diagram and it feels a bit random*” (Winnie, N,E).

Qualities.

The participants expressed interest in the list of qualities identified in the framework and suggested additions:

In 'Qualities' section I would like to see a quality I recall reading about when I studied this area of 'professional relativity', I think this is what it's called, it's about having reached a stage of sufficient ethical and professional maturity to be able to see and appreciate the value of all other disciplines as well as one's own. So one has lost the territorial or competitive arrogance that otherwise exists (could say commonly). (Isabelle, P, R)

I'd add supervisor reliability as being an important quality for successful supervision because my own research ... indicates that reliability was the most important criteria for successful supervision for Māori and Pasifika supervisees in the helping professions. Reliability is probably the first ingredient required for trust. (Donna, C/SW, E)

I wonder if trust could be an option to add under qualities, as in trust the process, trust your own abilities and skill sets (supervisee) and trust the supervisor as a professional in supervising. (Molly, N, E)

Mutuality could be added as a quality. (Ursula, Non, E)

Skills.

In a similar manner, the participants identified particular skills and skill areas which they thought were missing. The identification and management of power within the relationship were important for both Liz and Ursula:

I would add that a supervisor needs to have a good grasp of power dynamics and work to ameliorate these. For example, supervisees can view

psychologists as being quite powerful as there is a perception they hold knowledge other people don't have. Such a perception will colour any interaction between a supervisor or supervisee. Therefore it is critical to understand why a supervisee has chosen to approach you and what they are expecting from you. There needs to be a much greater sense of equality in interprofessional supervision. (Liz, P, R)

IS [interprofessional supervision] adds fuel to the debate of who is the expert and provides a forum to unpack issues of expertise and power imbalances and power differentials. (Ursula, Non, E)

Explicit skills for managing the difference, which included ensuring that the supervision was addressing the supervisee's professional responsibilities, were also identified as lacking:

With respect to skills, I would want to add the skill of tentatively holding and modifying hypotheses or double checking during the conversation how the ideas they are discussing would fit within the s'ee's [supervisee's] profession. ... What process can we add in that keeps the supervisor clearly focused upon the differences? ... It would be a 'strategy to address difference'. (Bella, C, R)

The agreement/contract and its negotiation caught the attention of participants who commented both on the content and the practicalities:

Under negotiation I'd like to suggest that there needs to be awareness of how a supervisor can inadvertently place their own professions' expectations/practice/ethics on a supervisee and that it is useful to discuss this when negotiating the contract considering how such a dynamic might be managed. (Liz, P, R)

I would probably add in something about intersectionality in the negotiation phase; sharing cultural fit and working to acknowledge personal differences which might oppress or which might lead to differing or diverging world views; differences such as ethnicity, gender and sexuality identification, socio-economic status etc. Finding common ground is also a part of this process ... I think intersectionality would actually fit really well into this model. (Donna, C/SW, E)

Feels to me like this [contract setting] is the key place where deep conversations will happen about the uniqueness of the relationship - do we need more guidance as to what these conversations might include? Not sure.... (Cathy, SW, E)

Elsie, pondered a similar 'how to' question when considering the process of determining the 'fit' of the relationship: "*the initial meeting to determine fit is really important however it*

can be difficult to know how to structure this to ensure relevant aspects are covered” (Elsie, N/C, R).

Sian, on the other hand identified a lack of review and process for ending the interprofessional relationship:

Perhaps the only other thing that could be added is review and closure of the supervision relationship. As with any supervision agreement, but perhaps more so for inter-professional supervision, it is important that the efficacy of the supervision relationship is reviewed regularly and the appropriate time to end the agreement is identified. (Sian, OT, R)

Finally, several participants offered comment on the benefits of interprofessional supervision.

Interprofessional supervision also offers a space to learn about differing supervision theoretical methods. For example, having supervision with an experienced narrative supervisor for example can assist a practitioner’s development as a narrative supervisor. (Nancy, N, E)

I think what is not clearly reflected is the added richness and depth of the supervision relationship by the nature of cross-discipline engagement. Emphasizing this added benefit and value, may encourage others who are contemplating a shift to inter-professional supervision. Another benefit ... is the benefit of the relationship stance of curiosity and ‘not knowing’ for both parties My guess is as a transferable skill this will be of benefit to clients as a therapeutic engagement skill as well. (Sian, OT, R)

How does this Supervision Differ from Same-Profession Supervision?

The final question asked the participants to consider how the interprofessional supervision framework differed from same-profession supervision. A common theme in the responses was that interprofessional supervision shared many of the characteristics and parameters present in same-profession supervision:

Good question: this framework would equally describe same-profession supervision. (Nick, OT, R/E)

There are many aspects that are the same actually especially when supervising an experienced practitioner from the same-profession. (Liz, P, R)

I can’t see that the framework differs too much from what is important regarding same-profession supervision maybe there is more emphasis on facilitating discussion although this should be the point of all

supervision practice. I like your point on accessing same-profession/other forms of supervision if necessary but again this concept would equally apply to same-profession supervision when for example cultural supervision might be useful. (Amy, MHN, R)

... these qualities seem important in all professional relationships, I'm not sure what to think about them in terms of being unique to interprofessional supervision. The qualities I would go after: Strong professional identity, solid supervision practice/experience, critical mind, creative. However, I would want that from a social work supervisor too! (Cathy, SW, E)

Other responses identified specific differences.

The value of 'not knowing', the associated sharing of knowledge and need to ask questions rather than give advice or make assumptions were aspects of interprofessional supervision which stood out:

Not-knowing/questioning/curiosity inquiry about professional mores. I think critical thinking/reflection (same thing to me) is a strength, as the ability to uncover taken-for-granted assumptions and question ideological professional practices is more likely. (Nancy, N, E)

With same-profession supervision there can be a tendency for the supervisor to be the expert giving content knowledge / advice, answers etc but in the interprofessional model the supervisor does not hold content knowledge to the same extent so the focus is on the supervision process and use of reflection, curiosity, skilful questioning. (Elsie, N/C, R)

... added awareness of the importance of not making assumptions – a skill that should be present in all supervision, opportunity to learn an engagement stance of curiosity and 'not knowing', easier to not fall in the trap of doing education but rather using evocation to draw out the supervisee's prior knowledge and encouraging clinical reasoning. (Sian, OT, R)

... both supervisor and supervisee need to be comfortable with 'not knowing', requires to be curious, open, really good communication skills, empathy, understanding, confidence and reflective practice. (Jean, SW, E)

The collaborative nature of interprofessional supervision, where knowledge, expertise and learning are negotiated and shared, was seen to reduce the power dynamics of supervision:

This differs from clinical supervision as the main focus is not on management of a case load and the power between the supervisor and the supervisee is shared in a different way. In interprofessional supervision the

way of working is supervisee led and collaborative rather than developmental or expert over. (Bella, C, R)

It's probably easier for this type to be co-constructed, because no matter how well intentioned; because of differing experience and competence levels, same-profession supervision tends to have that power imbalance and it's easy for a supervisor to find themselves in the expert role. (Donna, C/SW, E)

Understanding and working with difference, particularly different ethical and practice codes, were seen to provide different challenges and opportunities:

... it requires [an ability] to appreciate diversity and celebrate differences more. (Jean, SW, E)

Added richness and depth by the diversity brought to the relationship. (Sian, OT, R)

Shared discipline specific codes of ethics and standards of practice are not referred to [in interprofessional supervision] as part of providing guidance or exploring issues with the supervisee. (Hazel, SW, R)

However, Hazel continues, noting that because of difference there is the possibility of learning and connection:

In saying this, sharing a social work perspective and inquiring about whether supervisees have similar expectations eg "the social workers code of ethics refers to social workers taking reasonable steps to ensure the workplace is culturally appropriate to clients, are there similar expectations within your profession?" (Hazel, SW, R)

A number of participants availed themselves of the opportunity to add further comment and these comments have been woven into the four questions above. A cluster of responses also expressed appreciation of the research, affirmed their endorsement of the framework and commented on the place of interprofessional supervision in current practice:

Well done on creating an excellent framework. It is really easy to follow, yet captures so much of the essence of the relationship. (Sian, OT, R)

I notice that "interprofessionality" is becoming a skill that is as necessary as "professionalism". That interprofessionality requires many of the things I think you can emphasize in your model: curiosity, courage, an ability to say "I don't know" etc. (Leanne, C/S, R)

Discussion

The framework for interprofessional supervision was considered and critiqued by 23 expert informants. Overall, the participants were affirming. They agreed with the structures presented and at the same time offered useful comment, reflection and suggestions for development. The responses in this fourth phase however highlighted the need to reconsider the nature of the framework generated in the earlier phase three.

The primary aim of the research was to explore, describe and map the ways in which the participants of interprofessional supervision work with each other and engage in supervision practice. Participants in phase two were accordingly asked to explore ‘how they participate in and conduct interprofessional supervision’. The reported data thus considered individual practice, experience, underlying values and attitudes. In phase three, transcripts of interprofessional supervision sessions were analysed to provide a description of what happened in those supervision conversations. As presented in chapter seven, from the data of both these phases, two and three, the interprofessional supervision framework was developed and, in phase four, this framework was presented back to participants in the research.

When considering the interprofessional supervision framework in phase four some participants responded from a broad perspective and identified exceptions to the framework, drawing from experiences which had not been described in the initial interviews. The constraints on supervisees’ ability to choose, the attitudes of employers, managers and organisations, fiscal constraints and the engagement of new practitioners in interprofessional supervision are examples of this perspective. From these broader responses it became evident that the original intent of phase four, which was for the researcher, in collaboration with the participants, to develop a single, agreed map of interprofessional supervision, would not eventuate. As Tracy (2010) notes, the researcher has little control over what participants will say but does have the ability to open the space and allow participants to comment on and develop the data collected. What has been created from phase four therefore, is not a *definitive* map of interprofessional supervision, but rather what can be seen as a guide, *A Map for Interprofessional Supervision*.

The individual comments and the feedback of the participants have contributed a range of ideas and experience to this guide. With the benefit of hindsight, it could be suggested that interprofessional supervision is too new, too little researched and subject to too many variations and exceptions to be able to be mapped in a manner which suits all involved. Given that interprofessional supervision rests on the recognition and negotiation of

difference, it is possible that the original intent to provide a map was in itself an unrealistic task. The alternative guide to effective interprofessional supervision opens the possibility that there is not one way to conduct interprofessional supervision. The map charts the territory but not the route.

Participants offered suggestions for changes to wording, inclusion of additional factors and critiqued the presentation of the framework. All of these were most helpful to clarify and develop the framework and many of the suggested additions have been readily incorporated. Mutuality (Ursula), reliability (Donna), and professional relativity (Isabelle) have been included as qualities, while reframing (Bella) was added to the list of skills. Bella also noted that the word collaboration was not in the framework. This was a valuable observation as the process of interprofessional supervision, described and observed in the research, was collaborative and yet that description had not been applied. Collaboration was therefore added to the framework as descriptive of the process of the session. Finally, prompted by Sian's feedback, the important exercise of reviewing the supervision process and relationship has been added to the elements to be included in the agreement/contract discussion and negotiation.

A number of comments, as recognised by Sian, addressed areas which were "extrapolated in the thesis but not evident in the summary". Winnie asked for a definition of interprofessional supervision and Bella challenged the use of the term practitioner, noting that it excluded those 'professionals' who did not 'practice'. These comments highlighted the lack of context of the framework when it was considered as a stand-alone document. The relationship between the different elements in the framework diagram was also queried. "*I find the diagram a bit confusing. I don't clearly understand from the diagram or the video whether there are any implied relationships between these different elements or not*" (Leanne, C/S, R). A two paragraph introduction to the framework was therefore added to provide a more comprehensive base from which to understand the material presented.

Other comments also alluded to, and questioned, aspects of interprofessional supervision practice which have been covered in earlier sections of this thesis. Cathy, noting that the negotiation of the contract was where "*deep conversations*" would occur, wondered if "*we need more guidance as to what these conversations might include?*" Elsie had similar wonderings about the conversation which determined fit, noting that "*it can be difficult to know how to structure this to ensure relevant aspects are covered*". These are important questions which seek practical guidance for specific activities but are beyond the scope of the framework presented. Both of these aspects have been discussed in chapter six. Nick's

question about why we choose interprofessional supervision has also been covered in that earlier chapter.

Other participants added to and extended earlier discussion in the thesis about different elements in, and contributing to, the framework. Trust, which is discussed extensively in chapter six, is not mentioned in the framework. In her feedback, Molly suggests that trust should be included as a quality, whereas Donna regards trust as a component of reliability, stating that “*reliability is probably the first ingredient required for trust*”. Meanwhile Elsie notes that trust “*takes time to build*”. In light of these comments a sentence “*the process of negotiating the interprofessional supervision contract contributes to the building of trust between the two parties*” has been included in the framework. Alice contributes to and broadens the understanding of trust by reflecting on how trust, for her, changes when she is supervising someone whose professional background and experience are not familiar to her and for which she has no basis for evaluation, “*... and how much more I need to feel trusting of the supervisee if it is interprofessional than same*”.

The reflections and comments on the management of power and difference provide similar examples where the participants have extended earlier discussion. Difference, though well canvassed in earlier chapters, in the framework is only referred to in the negotiation of the agreement/contract as an element to be acknowledged and planned for. Power is not mentioned. Management of power and difference has thus been included as a supervisor skill in response to the feedback from several participants (Ursula, Liz, April, Bella). Jean’s suggestion that interprofessional supervision required participants “*to appreciate diversity and celebrate differences more*”, also covered earlier in chapter six, has been included as a participant quality. The general discussion centring on difference was extended by Agnes and Donna. Agnes’ personal reference to difference in sexual orientation and religion leads into Donna’s suggestion that “*intersectionality would actually fit really well into this model*”.

Intersectionality, informed by a critical post-colonial perspective, is described by Hernández and McDowell (2010) as:

a lens to address a group’s intersections of privilege and oppression relative to ethnicity, sexual orientation, class, ability, nation of origin, religion, and gender as they stand in social context. The importance of a specific, contextual, and hierarchical analysis is emphasized because oppressions are not equivalent across contexts. (p. 31).

This perspective acknowledges the power which is “embedded in the supervision relationship” and provides a platform from which supervision participants can conduct conversations which recognise and address “similarities and differences relative to power, privilege, and oppression” (Hernández & McDowell, 2010, p. 34). Although difference has been widely discussed in the previous chapters and has included reference to difference which is broader than profession, intersectionality has not previously been considered as a component of interprofessional supervision. This inclusion in the framework thus provides a valuable extension in approach to interprofessional supervision.

The ability of the participants to choose interprofessional supervision, was positioned as a central and important component of the framework. This was challenged by Tony, Jean and Leanne whose experience, particularly for supervisees, was otherwise. The tension between what is ‘best practice’, leading to effective interprofessional supervision, and what occurs in real time, is evident. Jean, who did not have a choice of supervisor, felt unsupported in her profession specific developmental needs, while Tony recalled supervisees ‘being instructed by a manager to see me’. Leanne, on the other hand, observed that increasingly in interprofessional work contexts, there was an expectation for interprofessional relationships, including supervision, for everyone regardless of practice experience. In this example, interprofessional supervision was the norm. Choice it is thus seen is not always present in interprofessional supervision arrangements.

The relationship between choice, trust, and effective (‘good’) supervision has been well documented (Davys, 2002; Hupcey, Penrod, Morse, & Mitcham, 2001; O’Donoghue, 2012; Sloan & Grant, 2012). The ability to choose a supervision partner, thus affirmed in the literature as a key element in successful and effective supervision, is important to be included in a map for effective interprofessional supervision. The feedback from the participants is therefore considered here as information which adds to the overall context, and identifies constraints to the practice of interprofessional supervision, but which does not always usefully contribute to the guide.

A number of comments referred to the diagrammatic component of the framework. Sian’s suggestion that the “*underlying propositions*” box really is the circle rather than a box” has been adopted and supervision knowledge and training and practice experience are positioned to encircle the interprofessional supervision exchange and renamed as Ideal Prerequisites. This positioning reflects the commentary on these two issues from the participants. That both supervisor and practitioner have practice experience and knowledge of supervision, in interprofessional supervision arrangements, is acknowledged and depicted as important.

Several participants (Isabelle, Elsie, Tony, Winnie) queried both the position within the model and the name of the fifth characteristic, supervision portfolios. The idea that all supervision needs may not be addressed in one relationship has been well canvassed, particularly in the social work supervision literature (Beddoe & Davys, 2016; Davys, 2002; 2017; Garrett & Barretta Herman, 1995; Hirst, 2001; O'Donoghue, 2015) and a number of terms have been used to describe the assortment of activities and relationships which can effectively supplement single supervision arrangements. Feedback from the interprofessional audience in this current research, however, demonstrated confusion about the chosen term, supervision portfolio, used in the interprofessional supervision framework. Isabelle's reflections on the "nest of supportive collegial relationships that have different functions" and her wonderings about the full range of relationships which support practitioners and professionals, were useful and extended the scope of this aspect of the model. The term supervision portfolio was, on reflection, considered to be too narrow and excluding of a number of important relationships which can address the breadth of practitioners' professional needs:

...how many other types of relationships might help 'hold' the person in their work from the point of view of boosting resilience in a relational way? Perhaps there are less formal peer arrangements (perhaps labelled 'consultation') which specifically target an individual's emotional support needs. (Isabelle, P, R)

Accordingly, to reflect this breadth, the term supervision portfolios has been changed to *Other Professional Relationships*. Also in response to feedback which suggested that its position was somewhat 'random' (Winnie), *Other Professional Relationships* has been positioned centrally alongside the core component *Session*. In this way it is intended to indicate that *Other Professional Relationships* are not an afterthought but are discrete and purposeful relationships which support and resource the practitioner.

Given the understanding that the final Map for Interprofessional Supervision, constructed from the interprofessional supervision framework as a result of the comments and feedback from the participants, is a flexible guide rather than a blueprint for interprofessional supervision practice, an amendment has been made to the terminology. In order to reflect this flexibility the term component has replaced the term characteristic which was used in the original framework.

Two comments extended beyond the scope of this study. Awareness of the broader contextual factors which they raise, however, provides a series of questions which may be

helpful for both supervisees and supervisors to explore when initiating or reviewing interprofessional supervision arrangements.

First is the question of the response, attitude, and position of employers with regard to interprofessional supervision. *“The context of the relationship: how it is viewed by the employer, and any challenges raised by that which are processed in supervision”* (Nick, OT, R/E). Second, Tony asks a raft of questions to further consider and determine the practice experience which is necessary for supervisees in order that they can usefully engage in interprofessional supervision:

Experience of supervisees accessing interprofessional supervision - it would be important to know more about this - how much experience? Would there be any parameters? Who makes this decision? How would interprofessional supervision arrangements become established? How may this typically occur? (Tony, SW, R)

The final question posed to the participants was to consider how the framework of interprofessional supervision differed from same-profession supervision.

This question drew responses which fell into two groups. First those who felt that interprofessional supervision, as described in the framework, differed very little from same-profession supervision. Second those who described the differences in terms of the deficits of same-profession supervision and the advantages of interprofessional supervision.

In the first group, Linda and Elsie noted that the essence of interprofessional supervision is reflected in its focus on supervision practice and supervision process. Linda observed that interprofessional supervision is *“... where the model and understanding of supervision is more “important” than knowledge of the discipline the supervisee works in...* (Linda, C, E).

Within the broad literature on supervision typical models include the following points. First, the understanding that supervision is about learning *“the heart of supervision is learning—the learning of the supervisee”* (Carroll, 2010) and *‘the medium for learning in supervision is reflection’* (Carroll, 2009b, p. 49). Second, they include lists of skills and qualities that indicate that the supervisor needs to be able to *“value exploration, tolerate uncertainty, accommodate difference and remain open and curious about possibility* (Davys & Beddoe, 2010, p. 130). Third is the proposition that difference is managed through *“an open and enquiring attitude”* and *“dialogue in which both parties participate in the learning”* (Hawkins & Shoheit, 2012, p. 114). These characteristics of supervision, which are independent from, and are not reliant on, profession-specific knowledge, were noted by the participants to be

present in interprofessional supervision. Examples from the participants include: facilitation of discussion (Amy), uncovering of assumptions, promoting critical thinking and reflection (Elsie, Nancy, Sian, Jean), mutual learning, collaboration, co-construction, (Bella, Donna, Alice). The supervision portfolio, which had the specific function in interprofessional supervision to ensure, amongst other things, lines of professional accountability, was also considered as appropriate for same-profession supervision (Amy, Leanne, Tony).

Leanne, endorsing the similarities, wondered if it is a matter of emphasis:

I wonder if a lot of the above needs to be phrased in terms of emphasis as it all applies to all supervisor relationships but some of it is more important, in my experience, in an interprofessional setting. (Leanne, C/S, R)

The second group of responses considered the deficits of same-profession supervision. The easy assumption of power, falling into the role of expert and providing information, were noted when the supervisor shared the same profession as the supervisee (Elsie, Bella, Donna, Sian, Linda). On the other hand, Jean, Sian, April and Hazel identified the richness and opportunity offered by the differences which were presented in interprofessional arrangements.

When contemplating the underlying propositions of interprofessional supervision several participants (Liz, Tony, and Olwyn), supporting the need for supervisees to have experience in or knowledge of supervision, commented on the difficulties which could arise if this was not the case. Hazel raises a different aspect of this issue when she describes supervision for those, such as support workers, who do not experience a culture of supervision or reflection in their place of work. When considering these issues it is difficult to separate interprofessional supervision experiences from same-profession supervision experience.

The non-regulated workforce, and many other professionals who come from work traditions which do not hold professional supervision as a component of work practice, may well benefit from supervision training and knowledge. However, all practitioners who are new-to-practice and/or new-to-supervision, from professions which do have supervision as a mandated practice, also go through a developmental curve in order to learn how to effectively use supervision. In many of these cases, as mentioned by Liz, it falls upon the supervisor to teach the supervisee about supervision.

The provision of training and understanding about supervision for supervisees, in order that they make the best use of supervision, therefore does not appear to be only pertinent to

interprofessional supervision but rather it is necessary for any person wishing to access supervision. Whether the supervisor shares the supervisee's profession or not, those new to supervision frequently need to be 'coached' to effectively use supervision.

The responses of 23 supervisors and supervisees to a framework of interprofessional supervision have been reported and considered in this chapter. The feedback and commentary has strengthened the framework and has also provided a broader perspective for interprofessional supervision practice. Congruent with the underlying proposition that the practice of interprofessional supervision must accommodate difference, so too must any framework of that supervision be flexible enough to accommodate such diversity. A new iteration of the framework titled A Map for Interprofessional Supervision, which has been developed in collaboration with the research participants, offers this flexibility.

A Map for Interprofessional Supervision

The Map for Interprofessional Supervision is not prescriptive and understands that there is more than one way to conduct interprofessional supervision. Common features of interprofessional supervision practice are included along with ideas and suggestions for best, or optimum, practice. The map charts the territory but the way in which participants prepare for the journey and plan the route will vary as the destination is negotiated between the explorers.

A Map for Interprofessional Supervision is presented in figure 8.1. Supplementary information which makes this a standalone document is contained in appendix 15.

A Map for Interprofessional Supervision

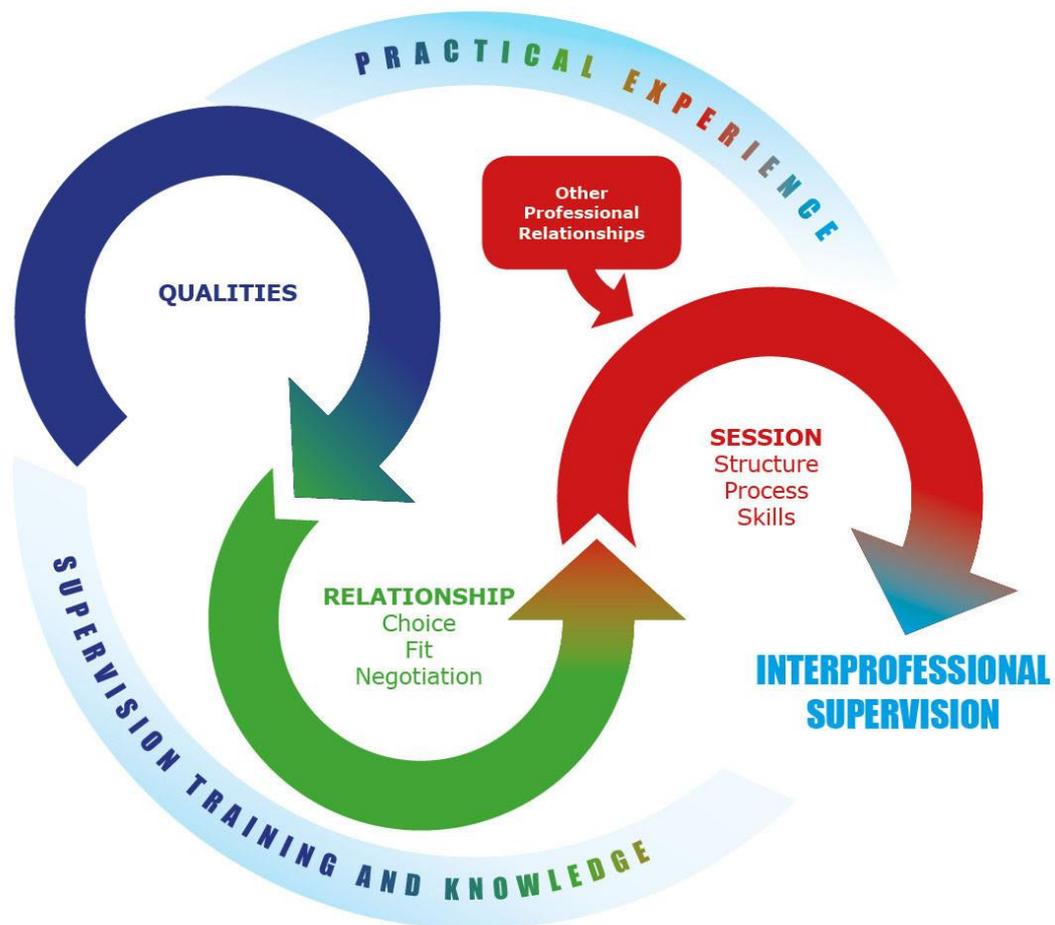


Figure 8.1. A Map for Interprofessional Supervision

Considering the findings from all of the phases of the research, the final chapter of this thesis identifies three elements which both shape, and are distinctive features of, interprofessional supervision. Interprofessional supervision is considered both as a practice in its own right and as an aspect of interprofessionality. Finally and importantly a new model of interprofessional working, The Diversity Model, is introduced.

Chapter 9: Navigating the Territory

This study explores interprofessional supervision as a separate and distinct mode of supervision practice. It describes and maps how the research participants, who were currently engaged in interprofessional supervision, construct and manage the interprofessional processes and relationships. Interprofessional supervision has been defined here as being where the participants of supervision, the supervisor and the supervisee, do not share the same professional training or practice.

The study has four phases. The first phase describes the context of interprofessional supervision in Aotearoa New Zealand through the examination of legislation, professional documentation and through interviews with representatives from five professional and/or regulatory bodies. In phase two, data from interviews with twenty nine participants, who were engaged in an interprofessional supervision relationship either as a supervisor or a supervisee, are reported and explored. Phase three describes the processes and interactions of interprofessional supervision sessions through the analysis of recordings of eight live supervision sessions. Data from phases two and three are combined to create a 'framework of interprofessional supervision', which, in phase four is presented to the original participants of phase two who were invited to provide feedback. The responses of the twenty three participants, who completed this phase, shaped the construction of a Map for Interprofessional Supervision. The findings of these phases of the research are reported in the preceding chapters.

The research considered two sets of questions. The context of interprofessional supervision was examined in chapter five through interviews with representatives of each of the five professions included in the research and by consideration of relevant legislation and policy and documentation from each profession. The views of the individual participants regarding matters such as choice, understanding of supervision and the reasons for engaging in interprofessional supervision were explored in chapter six. The second set of questions, which addressed the practice of interprofessional supervision and how difference was understood and managed, was presented through the reports of the participants in chapter six and through the observation of the 'live' practice presented in chapter seven. Throughout the interviews participants shared their thoughts about the difference between interprofessional supervision and same-profession supervision and this was specifically canvassed in phase four of the research when the participants provided comment and critique of the framework which had been constructed from the data at that stage.

The research, as noted in chapter four, was designed to construct a map of interprofessional supervision based on data obtained through the experiences of those who participated in this research. It was not the purpose of the research to either evaluate interprofessional supervision or to compare it with other forms of supervision. Again, as noted earlier, at times the participants were asked by the researcher to consider how interprofessional supervision might differ from same-profession supervision. At other times they were asked to identify the benefits or challenges of interprofessional supervision. On occasion, the participants spontaneously offered comparative or evaluative comments. All these comments have been considered as the personal and subjective opinion of individual participants which have added value to the collected data but which were not a substitute for structured comparative or evaluative research processes.

Chapter nine draws together the findings from all of the phases of the research. The discussion is set against the backdrop of interprofessionality where IPE and the development of professional identity, as presented in chapter three, are relevant and important factors. The findings of the research demonstrate the congruence between the social constructionist theoretical framework of the research which allows reality and meaning to be co-constructed between the participants and the researcher, and the processes of the practice of interprofessional supervision where meaning is negotiated and constructed by the supervision parties. As summarised by Elsie:

I have a very strong view about things being different and not right and wrong and so we had that discussion quite early that we might hold those different views and it is one of exploring the difference and the meaning of it and different perspectives. What different perspectives, the value of different perspectives in a situation. (N/C, R)

The chapter begins by revisiting the manner in which the term interprofessional has been understood and employed in the research and is followed by examination of three elements of interprofessional supervision which were developed from the overall consideration of the study:

- Interprofessional supervision: training and expertise.
- The dual perspective of professional identity and identifying as a professional.
- Interprofessional supervision as an aspect of interprofessionality.

Finally, a Diversity Model of interprofessional working is introduced.

The chapter concludes with a discussion of the overall findings of the research. The implications of the research are presented for those who mandate and resource professional supervision (registration and professional bodies, managers, educators and trainers) and for those who engage in interprofessional supervision (supervisor and supervisee).

Confirming the Terms

That the practice of interprofessional supervision has expanded as an activity well beyond the confines of what is traditionally or commonly regarded as a ‘profession’, is a finding of this research which is consistent with other observations on interprofessional supervision. “In many ways, supervision in interprofessional settings today is quite diverse, across a variety of practice settings and populations, moulded uniquely to agency and workforce factors” (Sweifach, 2017, p. 3). It is also a finding anticipated by earlier work, which examined the evolution and development of professions, for example Evetts (2003) and Kahlili et al. (2014).

The demographics of the twenty-nine supervisors and supervisees of phase two, as presented in chapter six, detailed participants who were affiliated to the professions of counselling, education, nursing, occupational therapy, psychology and social work and one participant who was employed in the non-registered social service workforce. The supervisees in this phase of the study described their supervisors as representing six professions: counselling, psychology, nursing, physiotherapy, psychotherapy and social work. The supervisors, on the other hand reported that they supervised, or had supervised, people who represented 29 different professions, occupations or workforce groups (see Table 5.4). It is worth noting that such breadth and diversity of supervision is masked if supervision research and study is conducted within the parameters of profession-specific practice.

This breadth of data challenges the parameters originally established at the outset of the study. Interprofessional supervision, it was stated early in the research, was “where the participants of supervision, the supervisor and the supervisee, do not share the same professional training or practice” and Townend’s (2005) definition of interprofessional supervision which centres on the terms ‘profession’ and ‘clinical’ competence was offered.

A contradiction is evident. Participants in this present study were asked to discuss and describe their experience and practice of interprofessional supervision. The resulting data showed that despite the name interprofessional, this practice of supervision for many included those from workforces which do not consider themselves (and are not considered by others) to be ‘professions’ and those from workforces where, while recognising an

interpersonal and relational aspect to their work, do not consider this to be a clinical component. Bella, in phase four (chapter eight), raised a similar point when she drew attention to the use of the word practitioner and the associated restrictions connected to that term.

The contradiction is recognised and accepted in this study. Rather than attempting to introduce a new and more inclusive term than interprofessional supervision, which may in turn only serve to add more confusion to the existing lexicon, the original term interprofessional supervision is retained. To clarify, and to complement the discussion on profession which was introduced in chapter one, in this research the term profession is employed as recognition of a discrete field of work. This field of work generally has parameters which define expectations of behaviour (which may at times be termed ‘professional’ behaviour), and includes accountability to a set(s) of standards, rules and codes of practice, though these may not be named as ‘professional codes of practice’.

Interprofessional Supervision: Training and Expertise

That supervision is a profession or a professional activity in its own right has been well canvassed in the literature (Bernard, 2006; Carroll, 2007; Falender & Shafranske, 2014a; Inman et al., 2014; Lizzio, Wilson, & Que, 2009; Sewell, 2018). Interprofessional supervision, as described in this research, accommodates a breadth of profession, occupation, work force, employment and experience. In the face of such diversity, the practice of supervision is seen to strengthen its adherence to the generic principles and theories of supervision and transcend individual professions. Interprofessional supervision itself is thus distinguished as having discrete and unique boundaries driven from the theories and practice of supervision not from the theories of practice. *“If anything there are times that I am careful that I am not being an OT, I am actually being a supervisor”* (Olive, OT, R/E).

In support of this proposition supervisors, the participants agreed, needed to be competent and have training and experience as supervisors. *“Unless they’ve really trained in some supervision they are usually coming from their discipline”* (Olive, OT, R/E). Although not the reality of practice for several participants, it is similarly argued that so too should supervisees, who were engaged in interprofessional supervision, have training or knowledge in supervision as well as experience in their field of practice or work.

Best practice in supervision.

It is important to recall the parameters of the sample of this research. Participants were selected in order that they “purposefully inform an understanding of the research problem and central phenomenon in the study” (Creswell, 2013, p. 156). To this end participants (supervisors and supervisees) who had a qualification or training, and experience, in professional supervision were recruited. The rationale behind this selection was that these participants would bring with them a level of knowledge of supervision theory, process and practice which would facilitate informed discussion and description of their interprofessional supervision experiences. This has proven to be the case but at the same time it has introduced new parameters into the research and raises questions. Is the supervision described and presented here representative of interprofessional supervision? Or is it representative of best supervision practice regardless of context? In chapter four it was suggested that the sampling process excluded those who had not chosen interprofessional supervision. The question posed here asks how are the research findings influenced by the views of those who have expertise in supervision?

The experience, qualifications and training of the participant group can be considered to influence the research data in two ways. First, to become a supervisor is generally regarded as a career development step which builds on experience in the relevant field of practice (Davys & Beddoe, 2000; Hawkins & Shohet, 2012). Whilst not all supervisors engage in supervision training or acquire a supervision qualification, this step is encouraged and recommended (Bond & Holland, 2010; Carroll, 2014; Hawkins & Shohet, 2012). Practitioners (and other people) who engage in supervision study and training therefore, it can be said, have mastered the early learning of their profession or occupation¹². Such was the case for the participants in this research, all of whom had a qualification or training in supervision and all of whom had more than five years of practice experience. Indeed, all of the supervisors and 11 of the fourteen supervisees had more than 11 years of experience in practice. This demographic has particular relevance to the supervisee group in that, although the research data includes comments and opinions about interprofessional supervision for new graduates or those new to practice, no person from either of these two groups participated in the study.

¹²The entry requirements of many supervision qualifications specify that the applicant has experience in their field of practice, or is already in the role of supervisor (Massey University; University of Auckland; Wintec)

Second, being knowledgeable about supervision and holding a qualification or having undertaken supervision training, it is argued, provides practitioners with the confidence and discernment to ensure that they access ‘good’ supervision which meets their needs. Supervisors, who have a supervision qualification and/or training, it is similarly argued, will strive to deliver ‘good’ supervision which addresses the supervisee’s needs and which incorporates the principles and theories of supervision practice. It is proposed that from this understanding of best supervision principles and practice the participants described how, from their experience, interprofessional supervision operated. This included: how they selected supervision partners, negotiated their supervision relationships, conducted the supervision session and importantly how they navigated difference.

As such, the supervision practice described here may not be representative or reflective of all interprofessional supervision experiences. The profile of interprofessional supervision presented here, it is contended, represents a standard and quality of supervision practice which represents *best supervision practice* which can be practised in any supervision context.

The Dual Perspective of Professional Identity and Identifying as a Professional

As already well established, the participants in this research were experienced practitioners. They were not in the process of developing their profession-centred professional identity. Professional identity and the development of the professional self however were themes constructed from the data sets of the study.

Participants recognised the importance of maintaining clear professional boundaries and, for many, a prerequisite for successful engagement in interprofessional supervision was that both the supervisor and the supervisee were strong in their professional identity. It was from this position of professional clarity that the participants reported that they gained a deeper understanding of, and engagement with, their own profession as a result of the interprofessional supervision exchange. Similar findings were reported by Banks (2004) who, seeking the experiences of senior practitioners of a youth offending and community safety service, explored, among other things, their interprofessional working. “Far from losing their sense of professional identity” she reports “for many of these practitioners, working in an interprofessional context may in fact encourage its strengthening” (Banks, 2004, p. 148).

The participants in the present study were not confused as to their professional role or its parameters, nor was there evidence that their professional identity was challenged or shaken or that they experienced any threat to their ideas or ethical principles. Working within the framework of interprofessional supervision, relationships and ways of working were negotiated and this, the participants reported, reinforced and developed, rather than threatened, individual professional identity.

It was considered important by participants that supervisees in interprofessional supervision were experienced in their field of work or practice and this experience was seen as an essential link to their professional identity. For interprofessional supervision to be successful both supervisees and supervisors, the participants said, needed to be professionally secure in that identity in order to engage with one another openly and without defensiveness. *And I think that it probably had more benefits than challenges or limitations particularly for somebody who does have a strong professional identity and, you know, some years of experience* (Linda, C, E).

Secure in their knowledge of who they were professionally, and contained within the safety of an agreed and negotiated working agreement or contract, it could be said that the participants in this present research described partnerships which moved beyond the “effective joint working” of Hudson’s (2002, p. 7) definition of interprofessionality. Rather D’amour and Oandasan’s (2005) definition of interprofessionality as the “development of a cohesive practice between professionals from different disciplines” (p. 9) appears to be a more accurate reflection of their experiences. At the same time the experiences reported in the research are perhaps best reflected by Sylvester et al.’s (2017) view that interprofessionality “appears as a reflective, integrative, and cohesive process in which professionals are engaged, with each other ... in continuous interaction and knowledge-sharing to address a variety of care and advocacy issues” (p. 205).

Just as it was considered important for the interprofessional supervisor to hold a set of supervision and professional skills, competence and knowledge, so too was the interprofessional supervisee, deemed to require a specific set of skills and professional perspectives. Secure in *who* they were in their own profession, these supervisees could be described as moving from considering their *professional identity* to ‘*identifying*’ as a professional.

This development may also be mirrored in changed perceptions and understanding of professionalism. According to Cameron (2011) there is an inevitability to the conflict which

occurs at “the boundaries between professions ... as different groups compete to assert their claims of expertise as professional knowledge and practice develops” (p. 54). Khalili et al. (2014) however, tracing the development and evolution of professionalism in western societies, and building on Evetts’ (2003) earlier work, describe a shift at these professional boundaries. From “markers of difference”, where professions protect membership, knowledge and practice, professionalism has shifted Khalili et al. (2014) suggest, to an interactionalist position where professional boundaries mark “important interfaces that enable communication across communities” (p. 95). The development of “dual professional and interprofessional identities” they say

could assist professions and professionals at the individual and system levels to, on the one hand maintain their professional solidarity reducing their fear of ‘identity loss’, and on the other hand to develop a sense of belonging to the interprofessional community and effectively overcoming the negative consequences of out-group discrimination and turf wars. (Khalili et al., 2014, p. 95)

Khalili et al. (2014, citing both Dingwall & Lewis (1983) and Evetts (2003)) suggest that professional workers who sit at the interface of these dual identities can “now create and represent distinct professional values or moral obligations, but with restraint on interprofessional competition – interprofessional co-operation was now encouraged” (Khalili et al., 2014, p. 95).

Such dual positioning, it is proposed, is a feature of the interprofessional supervision dyads of this research. Here, the participants, strong in their own professional identity, joined in open communication and exploration of practice with ‘another’ from a different profession. Identity can here be considered to have moved to a higher order of identification. Professionals have moved from identifying *with* their profession (professional identification) to identifying *as* a professional.

Identifying as a professional includes a specific set of characteristics. When *identifying as a professional* supervisees have moved beyond the detail of practice and consider themselves and their work from a broader perspective. They understand and recognise the profession specific knowledge, theory and skills which comprise their profession. They appreciate the parameters which are determined by their professional or regulatory body and accept the responsibility to honour and comply with any standards, codes of practice, ethics or reporting. Within this understanding of professionalism is an acceptance of shared elements which include: trustworthiness, confidentiality and “quality of service in the best interests of both clients and health care providers” (Khalili et al., 2014, p. 95). They are, in short,

confident in their professional identity. Importantly, this confidence allows them to engage in discussion, debate, challenge (or even argument) at the interface between their profession and another profession without defensiveness, submission or feeling threatened. Diversity is welcomed as an opportunity for critique, understanding and learning.

Within the interprofessional supervision relationship supervisees understand their 'role' as a supervisee just as the supervisor understands his or her 'role' as supervisor. It is an interaction and collaboration between two professionals who operate from the different and distinct roles of supervisor and supervisee and who understand that whilst the purpose of the supervision is to facilitate the exploration, reflection and learning for the supervisee, the learning may be mutual.

Importantly, what is proposed here is that interprofessional supervision can be considered as a vehicle for moving professional identity to a higher order of 'identity as a professional'.

Interprofessional Supervision: an Aspect of Interprofessionalism

Interprofessionalism sits at the heart of interprofessional supervision, but interprofessional supervision has characteristics which set it apart from other forms of interprofessional learning and working: membership, choice and negotiated relationship.

Unlike the IPE studies previously described (chapter three), the participants in the present research were neither students nor trainees, nor were they new graduates. Also, the supervision which is explored and described was not particular to membership of any specific multi-disciplinary team. The interprofessional supervision practice as described in the data sets of this study differs from previous studies on interprofessionalism and can be distinguished by three features.

First, membership: the interprofessional supervision relationships in this research were one-on-one relationships, in other words they were relationships between two individuals. Most studies on interprofessionalism describe relationships between groups of professionals and/or students from different professions. These are often in the context of, or in preparation for, the interprofessional or interdisciplinary team. Here, group dynamics can also be in play and interactions and relationships are often described as responsive to the composition of the group and to the balance of professions. In the one-on-one supervision relationship the participants have neither the support nor the distraction of their same-profession peers nor their interprofessional colleagues. How this affects the supervision exchange and experience was not specifically explored in this research but no supervisee participant expressed any

vulnerability or diffidence from being in supervision without the presence of someone from their own profession. More often there was a sense of liberation at the invitation to take a closer critical look at their practice, aided by a different perspective which was free from a profession-specific lens and associated assumptions. Moreover, choice was a key element in these interprofessional relationships.

Thus, the second feature which sets this research on interprofessional supervision apart from most other interprofessionality studies is choice. With two exceptions, all of the supervisees chose to engage in supervision with a supervisor from another profession and all of the supervisors were at liberty to choose whether or not to engage in any particular supervision relationship. Choice, as has been established, is an important factor in the development of quality supervision (Bond & Holland, 2010; Davys, 2002; Davys & Beddoe, 2010; Scaife, 2009) and the act of choosing was seen as a critical factor in the success of the relationships in this study. Unlike the reported interprofessional experiences of many IPE students, the interprofessional relationships in this study were not imposed by the IPE curriculum. Nor (with the exception of one of the supervisees mentioned earlier) were they a requirement of the working environment. Supervisees demonstrated thoughtful assessment of their professional and supervision requirements and an equally thoughtful process of meeting those needs through choosing an appropriate supervisor. Such consideration when assessing their particular professional and developmental requirements, and when establishing a supervision relationship, suggests supervisees who, strong in their professional identity, are conducting themselves professionally. Supervisors similarly applied careful criteria to the process of agreeing to supervise someone from another profession.

As noted throughout the reports of the findings in this research, two of the 29 participants did not choose interprofessional supervision as their supervision arrangement of first choice. Winnie's preference was for a supervisor who shared her profession of nursing. A lack of nurses with supervision expertise forced her to look more broadly for a supervisor and her choice settled on a supervisor who was currently a counsellor but who had a nursing background. Winnie had the freedom to select her supervisor but when her preference for a same-profession supervisor proved unattainable she chose to select the next best option. On the other hand, Jean, a social worker, wished to be supervised by another social worker in order to meet initial social work registration requirements. Jean, however, was constrained by the organisation's policy which directed that all practitioners be supervised by a psychologist. Jean was at liberty to choose which of the psychologists, employed by the organisation, to approach for supervision. These two participants, the exceptions in the

sample, both contributed to all three practitioner phases of the research (phases two, three and four) and provided valuable perspectives to the data.

The interprofessional supervision experiences of Winnie and Jean, and the descriptions drawn from the transcripts of the actual recorded sessions which they provided, accorded with descriptions of the other participants for whom interprofessional supervision was the supervision of first choice. This synergy suggests that despite the ‘reluctant’ participation in interprofessional supervision, when the supervisor is experienced and trained in supervision, the processes and structures of interprofessional supervision demonstrate uniformity and stability. It is of interest to note that, in phase four, when responding to the framework which was constructed from the data of phases two and three, Winnie and Jean made the following comments:

I have always tried to use profession-specific supervisors in the past however this framework covers everything of what I believe is important in supervision. Nice job, you have a convert! (Winnie, N, E)

Fantastic framework. This is something I would like to see at my workplace to be actively used by supervisors and supervisees. (Jean, SW, E)

The negotiation of the supervision relationship is the third feature of interprofessional supervision which distinguishes it from other reports of interprofessional working. The individuals, the supervisor and the supervisee, who engaged in the interprofessional supervision, represented two separate professional or occupational groups. They brought with them to the supervision relationship their professional identity and affiliation to those individual professional groups. At the commencement of their work together in supervision these, and many other, differences were acknowledged, potential problems were identified and mutually acceptable ways of working together were established as a foundation for the ensuing supervision conversations. In short, a supervision contract was negotiated. Interprofessional supervision from this study is seen to rest on negotiation and on collaboration around difference. Difference is noted, valued and managed. Diversity competence, Falender and Shafranske (2014b) believe, is an “ethical imperative underlying all clinical practice and supervision” (p. 1033).

Unlike some interprofessional working as described earlier, where competition for resource, status, power and credibility may feature, the interprofessional supervision relationship, as presented here, is removed from the practice interface. In the introduction to this thesis Zorga’s (2002) definition of supervision was provided. When supervision is conducted as a

practice aligned to this definition, where the aim is to provide the supervisee with a reflective space within which to review, learn from and to develop his or her own practice and to build his or her professional identity, there is no competition for resource nor for status or recognition. That being said, study participants were aware of the possibility and the potential for status and professional positioning to interfere with the process of interprofessional supervision, for example Liz, (P, S), but took steps to address this early in the relationship and so to minimise risk that this posed to the supervision process.

A Diversity Model of Interprofessional Working

As argued above, interprofessional supervision is an aspect of interprofessionality which has distinctive features. The Map for Interprofessional Supervision developed from the findings of phases two, three and four and presented in chapter eight, portrays these features and in doing so represents a new way of interprofessional working. This new way of working has been named the Diversity Model. The participants of interprofessional supervision demonstrate how difference between separate professions (or work contexts) is chosen and how these differences are managed to develop supervision partnerships where diversity is valued and shared, and where new insights are created and learning occurs for both parties.

Interprofessionality has been described as an integrative and cohesive process. “A reflective, integrative, and cohesive process (Sylvester et al., 2017, p. 205), “a cohesive practice between professionals from different disciplines” (D’amour & Oandasan, 2005, p. 9). This cohesion, when applied to interprofessional supervision, introduces the opportunity and flexibility to create something new from the diversity within the supervision arrangement. Interprofessional supervision can be considered as ‘a cohesive *supervision* practice’ which is responsive to, integrative of, and fitting for, the participants and their different professional perspectives. The proposition is that interprofessionality, or the diversity which it brings, is the catalyst for the creation of something new.

From the evaluation of a programme aimed to integrate professionals in Sedgefield, County Durham, Hudson (2007) developed his two models of interprofessional working which were discussed in chapter three. A pessimistic model characterised by exclusion and competitiveness and an optimistic model characterised by the identification of commonality. As noted earlier, the optimistic model, with its incorporation of new professionalism (Hudson, 2007) describes some of the features characteristic of interprofessional supervision: “reflective practice, interdependent decision process, (patient as

empowered/colleagues involved), supported practice, collective responsibility, engagement, and specificity of practitioner’s strengths” (Hudson, 2007, p. 6).

Considering interprofessional supervision in this manner, as an aspect of interprofessionality, a third model of interprofessional working is proposed which can be added to those already identified by Hudson (2007). To the pessimistic and optimistic models is added the Diversity Model.

The Diversity Model incorporates elements of Hudson’s (2007) optimistic model through recognising and valuing the broad commonalities between participants, but at the same time the model identifies and welcomes the differences within these commonalities. It is accepted as a commonality that professional practice is accountable to specific professional codes and competencies but it is understood that this accountability will differ between professions. It is accepted that professional values will guide and prioritise practice and it is understood that these values and priorities are possibly different in different professions. It is accepted as a commonality that each profession rests on profession specific knowledge, but it is understood that that knowledge, and the theories which underpin it, are likely to be different. The Diversity Model understands that difference extends beyond profession and, most critically includes difference in power. Any interchange between two individuals will involve the need to recognise and manage power difference at every level: personal, social, cultural, political, economic and professional.

As in the optimistic model, a commitment to learning is central for both parties in the relationship and there is an understanding that there are multiple perspectives and many truths. Where the Diversity Model, Table 9.1, differs from the optimistic model is that diversity is not just accommodated, it is chosen, welcomed, valued and is celebrated.

Table 9.1 Diversity Model: Difference, insight and learning

Confidence of knowledge
Confidence of status
Confidence of professional identity
Acknowledgement and management of power
Individual acceptance of, and mutual responsibility for, professional accountability
Awareness of personal and professional values
Openness and commitment to learning
Exploration and celebration of diversity

Summary

This research explored, described and mapped the ways in which the participants of interprofessional supervision work with each other and engage in supervision practice. The values, knowledge and beliefs about professional supervision which underpin the decision by health, psychological and social service practitioners to engage in interprofessional supervision were included in this exploration and particular attention is given to how difference was identified, managed and employed within these interprofessional relationships. From this appreciation of difference the participants constructed meaning and understanding which provided the bridge to professional growth and development.

From the data set of this study interprofessional supervision was identified as a distinct mode of supervision not just by membership and structure, but also by form and process. A map was constructed to guide effective interprofessional supervision.

All of the participants in this research, with the exception of one supervisee, were from professions which were aligned to a regulatory or professional body (counselling, nursing, occupational therapy, psychology or social work). But it is evident from the conversations with the supervisors that the interprofessional supervision which they delivered covered a broad span of professions, occupations and workforces, a span reflective of the discourse which attends the evolution of professions (Evetts, 2003; 2011; Khalili et al., 2014).

Investigation of legislation, regulation and policy which underpin the professional practice of the participants (chapter five) reveals a lack of recognition of supervision as a professional activity by the nursing regulatory body. There is a preference by the other health, psychological and social service professions for same-profession supervision. Despite this preference for same-profession supervision there was no proscription of interprofessional supervision by either nursing or the other health, psychological and social service professions except for students, those new to practice and those with identified issues of competence or performance. For all this, it suggests confident professional identity and independence of decision-making that the participants in this research chose to engage in interprofessional supervision relationships. They were in agreement, however, with the professional and regulatory bodies that interprofessional supervision was not appropriate for students or those new to their profession or professional work. They also considered a lack of experience in supervision to be an obstacle to effective interprofessional supervision process.

The Map for Interprofessional Supervision (chapter eight) represents interprofessional supervision as a mode of supervision practice in its own right. Characteristics of interprofessional supervision included choice, negotiation, collaboration, trust, open enquiry, exploration, and support. The process of supervising across professions provides supervision that is reflective and supervisee driven. The supervisor, without profession-specific knowledge and frameworks, conducts supervision through curiosity and exploration, opening space for reflection and critical analysis rather than offering advice, instruction or direction. Interprofessional supervision is considered to be similar to same-profession supervision but with different emphasis.

The requirement that participants in the research were experienced in supervision and held a supervision qualification, or had undergone training in supervision, provided expert informants. The supervision described by them can therefore be regarded as having been shaped by the principles of 'best supervision practice'. The supervision they described and demonstrated is reflective of their knowledge of supervision theory and process and is shaped by their identified supervision needs and the skills they bring to the supervision encounter as either supervisor or supervisee.

There is a caution therefore that the reported interprofessional supervision is unlikely to be representative of the reality of interprofessional supervision which is delivered in the professional work place, where participants frequently do not have training in supervision. The same, however, could be said of any same-profession supervision situation where the supervision partners do not have supervision knowledge or training.

What is contended here, however, is that interprofessional supervision is different, and that *difference* is the *difference*. Interprofessional supervision is a form of supervision which is located in diversity and premised on difference. It is argued that interprofessional supervision presents a new way of working interprofessionally. The Diversity Model promotes insight and learning through difference. Difference here is not only acknowledged and accommodated, it is sought after, claimed and celebrated. There is no search for objective truth or perspective and no knowledge is privileged over another knowledge. Understanding and connection are found through difference, meaning is constructed through collaboration and learning is mutual. The advantage of the Map for Interprofessional Supervision which is presented is that it provides an exemplar of how interprofessional supervision can be considered, what it can deliver and how it can be constructed, negotiated and conducted.

Difference featured at every step of the interprofessional supervision reported. The first step was the act of choosing this form of supervision with someone who was not from the same profession. The second step was the careful assessment of whether, despite the difference, this chosen relationship was a 'fit'. The negotiation of the supervision contract or agreement, the third step, amplified and examined the differences, accommodating and creating (among other things) agreed pathways to manage difference. Finally, the interprofessional supervision sessions were supervisee led, facilitated by the supervisor and provided the space for reflection and learning. This learning was often mutual and energising and assumed that there is more than one perspective. *'I'm not into 'you're this and I'm that'. I'm into 'we share common ground' and if we don't, you know, how exciting is that, let's explore'* (Donna, C/SW, E).

The sharing of perspectives, the different ways of viewing the world, and often, the opportunity to see one's own world through different eyes were central to the interprofessional supervision experience. *"It makes you think about your own profession as well and it does open your eyes to others perspectives"* (Helen, N, R). *"It really opens people's eyes to their own, if done well it can really consolidate their understanding of their profession"* (Nancy, NE, E).

Implications

This research challenges the traditions of same-profession supervision and so opens the possibility for new ways to consider supervision for professionals. For many, difference of profession between a supervisor and supervisee has been considered to be a threat to professional autonomy and professional standards (Berger & Mizrahi, 2001; Crocket, Cahill, et al., 2009; Hair, 2013). This perceived need to defend and protect professional territory and professional identity has stood as an obstacle to interprofessional supervision and is possibly reflected in the reluctance of regulatory and professional bodies to fulsomely endorse this form of supervision.

The consensus of the participants of the research was that interprofessional supervision was best suited to experienced practitioners. Interprofessional supervision was considered to stand as a discrete and separate form of profession-neutral supervision. To ensure fidelity with this model of supervision, supervisors (and ideally supervisees too) require training in supervision. Within these constraints, interprofessional supervision is thus a valid alternative, or addition, to same-profession supervision.

The findings from this research demonstrate that interprofessional supervision can provide a rich supervision environment where professional identity and integrity remain intact whilst at the same time practitioners (supervisees) are assisted to grow and develop their practice. A Map for Interprofessional Supervision developed through the research process details five components of interprofessional supervision and provides a guide to those who wish to explore interprofessional supervision further.

Working with diversity and difference in an anti-oppressive manner is an explicit foundational premise of most, if not all, health, psychological and social service professions (Brown & Bourne, 1996; Falender & Shafranske, 2014b; Hair, 2014; Hawkins, & Shohet, 2012; Tsui, O'Donoghue, & Ng, 2014). Interprofessional supervision is a mode of supervision which encapsulates diversity and presents a model-in-action for managing and working with professional difference, thus providing a ready platform for recognising and valuing the myriad other differences of professional work.

This research has established a baseline for good, best practice interprofessional supervision and, as such, has laid the foundation for broader exploration in this area. Much is yet to be investigated in future research, including such foci as exploring the experiences of those who do not choose interprofessional supervision, undertaking a comparative study of interprofessional supervision and same-profession supervision, evaluating the effectiveness of interprofessional supervision on practice and determining optimal readiness of supervisees to engage in interprofessional supervision. The exclusion of the employer and organisational perspectives from the research may have had the unintended consequence of disguising one of the fundamental tensions of supervision. As identified throughout the previous discussions organisational and professional agendas frequently compete for resource and for authority and their intersection at the point of professional supervision has not been explored in this research. Exploration of these employer and organisational perspectives may reveal different levels of understanding and appreciation of supervision whilst at the same time introduce more pragmatic fiscal and structural considerations. Also to be explored are the role and benefits of supervision training and how, and to what extent, training affects the quality, practice and experience of interprofessional supervision.

The 'territory' and the 'map' have become apt metaphors for the findings of this research on interprofessional supervision and the context within which it occurs. Interprofessional supervision, when mapped onto the territories of supervision, interprofessionality and the separate specific professions, can be considered to span all of those territories, while at the same time maintaining unique and clear boundaries. When viewed against the territory of

supervision, interprofessional supervision can be considered to be a higher order of professional supervision practice. When it is grounded in sound supervision theory and knowledge, interprofessional supervision is profession neutral and demonstrates best supervision practice and process. When considered against the territory of interprofessionality, interprofessional supervision can be seen to transcend traditional competitive models of interprofessionality and incorporate a new model where diversity is welcomed rather than just managed. Finally, when considered as an aspect of profession-specific practice, interprofessional supervision supports rather than challenges professional identity. At the border of interprofessionality, professional practitioners who are secure in their professional identity step beyond the profession and identify as a professional.

Conclusion

This research is hopeful.

The Diversity Model of interprofessional working, on which interprofessional supervision rests, sets interprofessional supervision apart from many other interprofessional exchanges. Based on the principles of inclusion, celebration of diversity, respect for difference and valuing of professional knowledge, the Diversity Model moves from relationships of competition, suspicion and defensiveness to relationships based on inclusion, openness and a curiosity to grow and learn.

Interprofessional working is thus demonstrated through interprofessional supervision to have the potential to be a positive, strong and constructive experience. Within clear and articulated boundaries of professional accountability, the individual professional identity of supervision participants is seen to be strengthened, whilst at the same time participants move to identify as professionals. As described in the research interprofessional supervision demonstrates a standard of supervision practice which is founded on best supervision practice principles and which offers support, challenge and creative development for the supervisee and stimulation and thoughtful perspectives and engagement for the supervisor. As such, this account of supervision between participants from different professions can also stand as a benchmark for good supervision between those who share the same profession.

The research highlights the importance of choice of supervision partnerships and the fact that practitioners and supervisors themselves, when allowed choice, will often extend themselves and look in diverse places to meet their professional needs. Underpinning the findings of this research is the role of supervision education and training. A consistent message from participants is that effective interprofessional supervision is driven by knowledge of

supervision, not by practice (profession-specific) knowledge. Education and training in supervision is therefore something which all (practitioners, supervisors, employers, managers and professional and regulatory bodies) can consider, endorse and support as a means of adding value to all supervision arrangements and thence to add value to practice.

The research begins to fill a gap, recorded in the literature (Bogo et al., 2011; Hutchings et al., 2014; Simmons et al., 2007), by providing a map for setting up and for establishing an interprofessional supervision relationship, and for effective engagement in the interprofessional supervision exchange.

Opportunities are presented for experienced practitioners and supervisors who want to refresh and extend their practice, vision, skills and professional critique. In addition the research provides guidelines for managers and organisations to act outside the square and presents a template from which to encourage and introduce diversity into supervision arrangements. Professional and regulatory bodies may weigh the reported benefits of interprofessional supervision and support this form of supervision as a valid option for certain practitioners:

Interprofessional supervision recognises the value that comes from an enquiring, curious position, where the model and understanding of supervision is more “important” than knowledge of the discipline the supervisee works in. It is likely to enhance the supervisees practice because the supervisor really seeks to understand why a person/profession does things in particular ways. It levels the playing field in that neither person is the “content” expert for the other, so the supervisee really has to find their own solutions. When both are from the same-profession, there is more unevenness in the relationship, and more temptation to provide answers from one’s own experience. (Linda, C, E)

This research set out to map the interface between professional knowledge, practice imperatives and difference within the practice of interprofessional supervision. The Map for Interprofessional Supervision, produced through the research process, provides that map and in so doing establishes clear parameters which both shape and direct effective interprofessional supervision practice. At the same time the supervision described and experienced by the research participants, in their interprofessional arrangements, was seen to represent *best practice* supervision. When supervision promotes reflection, learning and development, the conditions necessary for effectiveness were seen to be independent of specific professional boundaries. Finally the research presents the Diversity Model and identifies interprofessional supervision as a working example of this model. In the Diversity

Model there is a richness of interaction and critique which are based on difference, not uniformity, and such difference is welcomed as inspirational and as a privilege.

Appendices

Appendix 1: Phase One Invitation



**EDUCATION AND
SOCIAL WORK**

Epsom Campus

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Auckland, New Zealand
T +64 9 623 8899

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www.education.auckland.ac.nz

The University of Auckland

Private Bag 92601
Symonds Street
Auckland 1135
New Zealand

**Interprofessional supervision: Mapping the interface between professional knowledge,
practice imperatives and difference.**

Dear XXX,

My name is Allyson Davys and I am currently undertaking a research study to fulfil the requirement of the degree of PhD in the School of Counselling, Human Services and Social Work at the University of Auckland.

The purpose of my study is to explore interprofessional supervision as a mode of supervision practice and to understand how the participants of interprofessional supervision construct and manage the supervision processes and relationships. Interprofessional supervision is defined, for the purposes of this study, as being where the participants of supervision, the supervisor and the supervisee, do not share the same professional training or practice.

Phase one of the research will describe the context for the practice of interprofessional supervision and I am seeking to interview representatives from different health, psychological and social service regulatory or professional bodies in order to understand the professional values, standards and mandates (professional and legislative) which each profession holds regarding interprofessional supervision.

I am inviting you, or a representative of your regulatory body, to agree to meet with me for an interview which will be approximately 90 minutes in length and will be conducted in a

location which is convenient to each interviewee. I have attached a Participant Information Sheet and Consent Form which provides more detail of the research.

I appreciate you taking the time to consider this request.

Allyson Davys

Counselling, Human Services and Social Work
Faculty of Education and Social Work
University of Auckland

027 224 4590

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Main Supervisor: Associate Professor Christa Fouché Head of School Counselling, Human Services and Social Work Faculty of Education and Social Work University of Auckland 09 623 8899 ext 48648 c.fouche@auckland.ac.nz	Co Supervisor: Associate Professor Liz Beddoe Counselling, Human Services and Social Work Faculty of Education and Social Work University of Auckland 09 623 8899 ext 8559 e.beddoe@auckland.ac.nz
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For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 21 August 2015. Reference Number 014955.

Appendix 2: Call for Participants



**EDUCATION AND
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The University of Auckland

Private Bag 92601
Symonds Street
Auckland 1135
New Zealand

Call for research participants

Interprofessional supervision: Mapping the interface between professional knowledge, practice imperatives and difference.

I am undertaking research for a Doctor of Philosophy in the School of Counselling Human Services and Social Work at the University of Auckland and am seeking practitioners who are currently engaged in an interprofessional supervision relationship and who hold a professional supervision qualification (graduate or post graduate) from either the University of Auckland or the Waikato Institute of Technology (Wintec). Participants in the research can be either a supervisor or a supervisee in the interprofessional relationship.

The aim of this study is to identify, describe and map the ways in which the participants of interprofessional supervision engage in supervision practice and work with each other.

Interprofessional supervision is defined, for the purposes of this study, as being where the participants of supervision, the supervisor and the supervisee, do not share the same professional training or practice.

I wish to invite participants to a semi structured interview to discuss their experiences, attitudes and values regarding interprofessional supervision and to identify the skills and processes which they use in their practice of interprofessional supervision. The research has a sequential design and there will be an opportunity to join two further phases of the research should they so wish. Participation in the semi structured interviews does not obligate them to join the subsequent phases nor will they be disadvantaged if they do not join either of the subsequent phases.

If you are interested in participating in this research please contact me adav112@aucklanduni.ac.nz and I will send you more detailed information. If you know of other practitioners who fit the criteria and who may be interested to participate please share this information or give them my contact details as below.

Thank you

Allyson Davys

Researcher:

Allyson Davys

Counselling, Human Services and Social Work

Faculty of Education and Social Work

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For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 21 August 2015. Reference Number 014955.

Appendix 3: Phase Three Invitation and Participant Information Sheet



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New Zealand

PARTICIPANT INFORMATION SHEET PHASE THREE: AUDIO RECORDING

TITLE

Interprofessional supervision: Mapping the interface between professional knowledge, practice imperatives and difference.

My name is Allyson Davys and I am currently undertaking a research study to fulfil the requirement of the degree of PhD in the School of Counselling, Human Services and Social Work at the University of Auckland.

The purpose of this study is to explore interprofessional supervision as a mode of supervision practice and to understand how the participants of interprofessional supervision construct and manage the supervision processes and relationships.

Thank you for participating in phase two of this research. You are now invited to contribute to *phase three* by agreeing to digitally record one, two or three live interprofessional supervision sessions. The sessions will take place in your normal setting and the audio recorder will be delivered to you by the researcher. The number of sessions you will be asked to record will depend on the numbers of participants in this phase of the research. In total between ten and twenty supervision sessions transcripts are sought.

To be eligible to participate your supervision partner (supervisor or supervisee) will also need to agree to participate in this phase (phase 3). A separate letter of invitation is available to give to your supervision partner.

In 2015 I will hold a part time teaching position at the University of Auckland on the post graduate professional supervision programme. As phase two calls for participants who are graduates of a supervision programme no current students will be involved in that part of the research process. If it should transpire however that the supervision partner, who you wish to invite to participate in phase 3 of the research, is a student on the supervision programme where I am currently teaching, I will not participate in any assessment of that student's work.

I am available, and willing, to meet with you and your supervision partner if there are any questions you would like to discuss in person.

OVERVIEW OF THE STUDY

There are four phases to this research.

Phase one will identify the broad professional context in Aotearoa New Zealand within which interprofessional supervision is practiced. Phase two will explore the experiences, attitudes and values of expert stakeholders and the skills and processes which are used in their practice of interprofessional supervision. *Phase three* will describe the process of the practice of interprofessional supervision through direct observation of supervision in action. In phase four the preliminary findings from phases two (framework) and three (description of the supervision process) will be presented, through focus group(s), to volunteers from phase three. The participants will be invited to collaborate in the co-creation of a map for interprofessional supervision practice which is based on current practice.

The design of this research is sequential. Participants from phase two are invited to join phase three and to also participate in stage four.

Following the recording of the session(s), should you or your supervisor (or supervisee) so wish, there will be an opportunity to debrief with me (the researcher).

If you are involved in phase three, there is a further opportunity for both you and your supervision 'partner' to join a focus group to co-create a map of interprofessional practice based on the combined descriptions and practice findings of phases two and three.

Inability, or disinclination, to be involved in phase four by either you or your partner is not a barrier to participating in phase three of the research.

CONFIDENTIALTY

The material gathered from the recorded sessions in phase three will contribute to inform a framework for understanding interprofessional supervision practice. No material will personally identify you but broad demographics will be collected and include such things as participants' profession and practice experience. The interviews will be recorded using an audio recorder and to avoid the possibility of identifying a person or persons (colleague, practitioner from another organisation or patient/client) in the audio recording I recommend that you use a non-identifying pseudonym(s) to preserve that person's anonymity. Should any identity be inadvertently revealed in these recordings it will be anonymised by the researcher.

Professional assistance will be used to assist with transcribing the recordings. The transcriber will sign a form to agree to confidentiality and professional standards will be maintained.

Raw data and transcripts will only be seen by the researcher and transcriber. Should you wish to review the transcript to check the data and to ensure anonymity has been achieved I will forward you a copy at your request for this purpose. Any hard copy documents will be stored in a locked cupboard throughout the duration of the study and electronic files will be kept on a secure password protected computer. These files will be kept for six years and then destroyed.

RIGHTS

If you agree to take part in this research you will have the right to:

- Refuse to answer any question and to withdraw from the research at any time.
- Ask any further questions about the research at any time during your participation.
- Request that the audio recorder is turned off at any time.
- Provide information on the understanding that it is completely confidential to the researcher and that it will not be possible to identify you in any of the reports of the study.

- To be given access to a summary of the research findings when the research is completed.
- To be assured that all raw material including audio recordings will be kept in a secure place during, and on completion of, the research.

RESULTS

A summary of results will be available to be read by participants. The findings will also form the basis of academic papers which will be submitted to peer-reviewed journals with a view to publication.

Researcher:

Allyson Davys
 Counselling, Human Services and Social Work
 Faculty of Education and Social Work
 University of Auckland
 027 224 4590
adav112@aucklanduni.ac.nz

<p>Main Supervisor: Associate Professor Christa Fouché Head of School Counselling, Human Services and Social Work Faculty of Education and Social Work University of Auckland 09 623 8899 ext 48648 c.fouche@auckland.ac.nz</p>	<p>Co Supervisor: Associate Professor Liz Beddoe Counselling, Human Services and Social Work Faculty of Education and Social Work University of Auckland 09 623 8899 ext 8559 e.beddoe@auckland.ac.nz</p>
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For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 21 August 2015. Reference Number 014955.

Appendix 4: Phase Four Email

Dear XXX

As you will recall, sometime in the past two years you were generous enough to speak with me about your experiences and ideas about interprofessional supervision. I have now completed the review and analysis of the interviews and supervision sessions and from that data have constructed a framework of interprofessional supervision.

This email is to invite you to participate in the fourth phase of my research by commenting on the framework, which has been summarised into an 8 minute video, and answering four questions. I am expecting that this will take about 30 mins in total.

I have attached an information sheet for this phase of the research.

If you are interested and willing to participate please let me know by return email and I will forward the relevant material.

Thanking you in anticipation

Allyson

And... there is the enticement that all those who participate in phase four will go into a draw for a \$50.00 Westfield voucher!

Appendix 5: Phase One Interview Schedule



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INTERVIEW SCHEDULE

PHASE ONE: CONTEXT

Regulatory/professional body.

Demographics

- 1) Position held
- 2) Length of time in position
- 3) Profession
- 4) Practice experience
- 5) Experience of supervision

General

- 6) Can you tell me how professional supervision occurs within your profession?
- 7) What is the mandate for professional supervision for your profession?
- 8) What are the expectations of the regulatory/professional body as regards supervision?

Interprofessional supervision

- 9) How does the regulatory/professional body regard interprofessional supervision?
- 10) Is this an area of practice which, to your knowledge, is discussed and debated within the profession?
- 11) If interprofessional supervision is practised by practitioners (supervisors or supervisees) of your profession are there situations where the regulatory/professional body would not support this practice?
- 12) Other comments and observations

Thank you

Appendix 6: Phase Two Interview Schedule



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INTERVIEW SCHEDULE

PHASE TWO: EXPERT STAKEHOLDERS

Demographics:	<p>What profession do you belong to?</p> <p>What profession does your supervisor/supervisee belong to?</p> <p>Age range 20-30 31 – 40 41- 50 51- 60 60 – 70 70 +</p> <p>Ethnicity</p> <p>Gender</p> <p>Employment sector</p> <p>Is there an interprofessional aspect to your work context?</p> <p>How many years have you been in professional practice?</p> <p>What supervision qualification do you hold?</p> <p>When did you graduate?</p> <p>How many years have you been either providing or receiving supervision from someone of another profession?</p> <p>How many interprofessional supervision relationships have you been engaged in and for what periods of time?</p>
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	<p>How long have you been in this current interprofessional supervision relationship?</p> <p>Is it an internal or an external supervision arrangement?</p> <p>How frequently do you meet?</p>
Choice	<ol style="list-style-type: none"> 1. As a supervisee: 2. As a supervisor:
The initial contact and contracting process:	<ol style="list-style-type: none"> 3. Can you tell me about the initial conversations and contracting process between you and your supervisor/supervisee? 4. What are the aims of your interprofessional supervision? 5. How, if at all, were your conversations and supervision contract different from a same profession supervision contract?
Supervision sessions	<ol style="list-style-type: none"> 6. Can you tell me about your actual supervision sessions? 7. How would you describe the process of your interprofessional supervision? 8. How is interprofessional supervision different from same profession supervision?
Professional identity	<ol style="list-style-type: none"> 9. How do you see or describe your profession in relation to other professions?
Overview	<ol style="list-style-type: none"> 10. What are your thoughts about interprofessional supervision? <p><i>What are the benefits of interprofessional supervision for you?</i></p> <p><i>What are the challenges or limitations of interprofessional supervision for you?</i></p>

Thank you

Appendix 7: Phase Four Email Stage Two

Dear XXX,

Thank you for agreeing to participate in phase four of my research.

I would like you to watch an 8 minute video and consider four questions:

1. How well does the framework reflect your understanding and practice of Interprofessional supervision?
2. What is missing?
3. What would you like to remove or modify?
4. How does this supervision differ from same- profession supervision?

And I would be appreciative of any other comments you may wish to add.

Your feedback does not need to be long or detailed (unless you wish it to be) and bullet points are fine.

I have attached the questions (and an overview of the framework) in a word Doc so that, if you wish, you can print them off and make notes as you watch the video.

To access the video please use the link to the University of Auckland drop box which will have been sent to you by separate email. The video may take a while (about 5 – 6 mins) to download and will be available for collection for two weeks. If you have any problems please do not hesitate to contact me. adav112@aucklanduni.ac.nz

I would be appreciative if you could email me your response by XXX. In the video I ask you to send back a consent form. This is no longer necessary as I will regard any comments and feedback as indicative of your consent to participate in this phase of the research. Please delete the video when you have finished.

Many thanks

Allyson

Appendix 8: Phase Four Framework, Model and Questions



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Interprofessional supervision: Mapping the interface between professional knowledge, practice imperatives and difference.

Phase Four: Feedback

Thank you for taking the time to participate in this phase of my research by providing feedback on the interprofessional supervision framework which is included here. Four questions are posed below to assist your feedback .Please email your response to me at adav112@aucklanduni.ac.nz.

Your feedback does not need to be long or detailed (unless you wish it to be) and bullet points are fine.

1. How well does the framework reflect your understanding and practice of Interprofessional supervision?
2. What is missing?
3. What would you like to remove or modify?

4. How does this supervision differ from same- profession supervision?

And I would be appreciative of any other comments you may wish to add.

Allyson Davys

Counselling, Human Services and Social Work

Faculty of Education and Social Work

University of Auckland

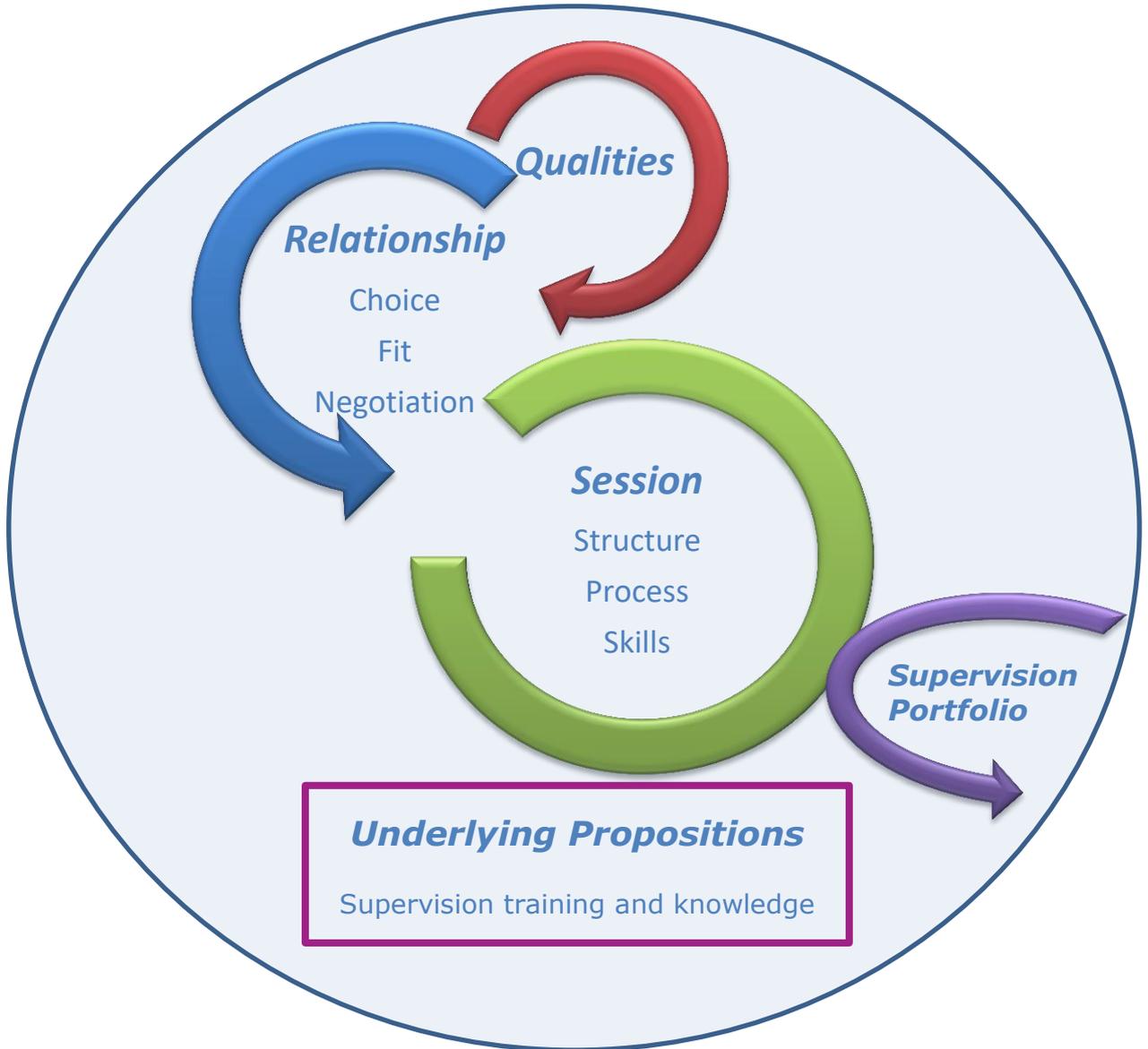
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<p>Academic Head of School: Dr Allen Bartley School of Counselling, Human Services & Social Work Te Kura Tauwhiro Tangata Faculty of Education and Social Work University of Auckland 09-623-8899, x.48140 a.bartley@auckland.ac.nz</p>	

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APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 21 August 2015. Reference Number 014955.



Interprofessional Supervision: A Framework

Interprofessional Supervision: A Framework

1: Propositions:

Supervision training and knowledge: This is regarded as essential for supervisors and preferable for supervisees.

Experience: Interprofessional supervision is most often accessed by, most relevant to, and appropriate for, practitioners (supervisees) who are experienced practitioners.

2: Qualities:

Supervisors & supervisees in interprofessional supervision both need to demonstrate: *authenticity, openness, curiosity, empathy, respect, confidence, courage, humility, willingness to learn.*

3: The Relationship:

Choice:

The ability, or the freedom, for both supervisor and supervisee to choose whether to engage in a particular supervision relationship is important.

Fit:

An initial meeting between the supervisor and the supervisee is important to determine whether the relationship has the potential to meet the supervisee's needs and for both parties to determine whether there is an appropriate 'fit' of expectations, skills values and personality.

Negotiation:

The supervision contract and the discussion, disclosure and negotiation which accompany it are critical. The contracting process acknowledges and clarifies: the expectations and parameters of supervision, the limitations and boundaries of knowledge, difference and the strategies to address difference, and the supervisee's accountability to his or her own profession and clinical practice.

4: The Interprofessional Supervision Session

Structure:

Interprofessional supervision creates a space, or a learning place, where the supervisee can safely and honestly reflect and where his or her professional development and professional growth are supported.

There is a focus on the processes of practice, the structures and systems of practice, the supervisees' self-management, self-care, relationship-management and professional identity.

Topics for discussion are led by the supervisee and facilitated by the supervisor.

Very importantly supervision is driven through knowledge of *supervision* practice as opposed to *profession specific* practice.

Process:

The responsibility to ensure that relevant professional accountability and professional responsibilities are covered for the supervisee is *shared* between supervisor and supervisee.

Curiosity, openness, tolerance of 'not knowing' and a range of questions assist in avoiding the trap, and danger, of making assumptions.

Skills:

A range of skills and interventions are used by the supervisor with particular emphasis on: open reflective enquiry, challenge, attentive listening, paraphrasing, summarising, affirmation, feedback.

5: Supervision portfolios:

Many supervisees also access alternative forms of professional relationships, which address areas not covered in interprofessional supervision, in particular: supervision, consultation or management accountability for profession-specific clinical practice.

Appendix 9: VideoScribe Voiceover

Phase four

Video presentation - voice over

Greetings all- Thank you for taking the time to watch this video.

In the two years since I spoke with most of you I have been busy working on and analysing the interviews we did together. Based on this I have come up with a framework for interprofessional supervision which I will present here in this video - and I hope that the presentation will help you to understand where I have got to and help you respond to the questions I have posed.

These four questions ask you to consider:

1. How well does the framework reflect your understanding and practice of interprofessional supervision?
2. What is missing?
3. What would you like to remove or modify?
4. How does this supervision framework differ from same- profession supervision?

And I would be delighted with any other comments you may wish to add.

So – starting with an overview of the framework:

Essentially, the interprofessional supervision framework has five key characteristics

1. First - It rests on two propositions – one which relates to training in supervision and the other which describes a profile of the supervisees who typically engage in interprofessional supervision.
2. Second -Particular qualities are identified which were thought to be needed by the participants
3. Third -The relationship, which is central, is seen to be shaped, in interprofessional partnerships, by three factors: choice, fit and the negotiation of the contract
4. Fourth - The interprofessional supervision session has a structure, a process, and there are particular skills employed by the supervisor
5. Finally – many supervisees also access additional professional relationships, in the form of supervision or consultation, to address profession-specific clinical practice.

So the framework in more detail:

Characteristic 1:

Two propositions underpin the framework:

1. that supervision training and knowledge are essential for supervisors and are preferable for supervisees.
2. that interprofessional supervision is most often accessed by, most relevant to and appropriate for, practitioners (supervisees) who are experienced practitioners.

Characteristic 2:

A number of qualities were identified as being important for both supervisors & supervisees to demonstrate and these include:

authenticity, openness, curiosity, empathy, respect, confidence, courage, humility and a willingness to learn.

For example:

- The ability and willingness, of both parties, to learn
It's that genuine - are you actually interested and do you want to learn about it and journey with people around it and then if you do have that and you accept yourself as you are and that you are going to make mistakes along the way and you will learn with them, yeah that is all I can really say. (Supervisor)
- An appreciation, excitement and openness regarding difference
well I think you have to really value what the diversity can bring and not think that there is the right way. (Supervisor)

I'm not into 'you're this and I'm that'. I'm into 'we share common ground and if we don't, you know, how exciting is that - let's explore'. (Supervisee)
- It was important to be able to sit with 'not knowing'
If people have a really good understanding of each other, then they will feel less defensive and more able to communicate with each other, and call on other people's expertise, and recognise it is really important not to know everything. (Supervisee)
- Finally -participants in interprofessional supervision needed to have knowledge of themselves, their strengths and limitations and have the ability to acknowledge mistakes.

And I suppose probably you need to know who you are as a supervisor, you need to know who you are. So then you can hear who the other person is. (Supervisor)

I think being able to say as a supervisor, or a supervisee, “ I don’t know” or” I made a mistake” or “I can’t do that” or “I can’t help with that”, you know, that kind of honesty is very important. (Supervisor)

Characteristic 3:

The relationship was central to interprofessional supervision and three factors contributed to this:

First - **Choice**: this included the ability, or the freedom, for both the supervisor and the supervisee to choose whether to engage in a particular supervision relationship.

I guess I deliberately did choose her because she wasn’t a nurse. (Supervisee)

Second - what was described as ‘**Fit**’: This was usually determined in an initial meeting between the supervisor and the supervisee. Did the relationship have the potential to meet the supervisee’s needs and did both parties believe that there was an appropriate ‘fit’ of expectations, skills, values and personality?

Part of that is a gut feeling, and honesty is a large part of that and rapport. ...There’s the personal, the fit of the person and then there’s the fit of the profession and skill requirements to my background. So when it comes to the fit of the person to person there’s the need to feel trust in both directions. I can trust that person and they can trust me, would be number one. (Supervisor)

The third factor was **Negotiation**:

The supervision contract and the discussion, the disclosure and the negotiation which accompanied it were seen as critical. The contracting process acknowledged and clarified the expectations and parameters of the supervision, the limitations and boundaries of knowledge, difference and the strategies to address difference, and the supervisee’s accountability to his or her own profession and clinical practice.

No, I think as long as people have a contract and they are clear what they are getting involved in, and the knowledge of each party and the limitation of the knowledge of each party, then I think it is quite clear. (Supervisee)

Characteristic 4:

The Interprofessional Supervision Session:

this was also considered to have three components.

First, the **Structure**:

Interprofessional supervision created a space, or a learning place, where supervisees could safely and honestly reflect and where their professional development and professional growth were supported.

There was a focus on the processes of practice, the structures and systems of practice, the supervisees' self-management, self-care, relationship-management and professional identity.

Topics for discussion are led by the supervisee and facilitated by the supervisor.

And, very importantly, supervision was driven through knowledge and understanding of *supervision practice* as opposed to *profession specific practice*.

Second, the **Process**:

The responsibility to ensure that relevant professional accountability and professional responsibilities were covered for the supervisee was *shared* between supervisor and supervisee.

The trap, and the danger, of making assumptions was noted – and this was managed by maintaining curiosity and openness, tolerating 'not knowing' and asking a range of questions.

It was actually helpful because the questions that came were not from a knowing of 'oh this is what you would do', but rather 'well that is interesting, why is that?'

(Supervisee)

Third, the **Skills**:

A range of skills and interventions were used by supervisors with particular emphasis on: open reflective enquiry, challenge, attentive listening, paraphrasing, summarising, affirmation, feedback.

Characteristic 5:

Finally, supervision portfolios: Many supervisees also accessed alternative forms of professional relationships, which addressed areas not covered in interprofessional supervision. In particular supervision, consultation or accountability for profession-specific clinical practice.

Thank you for watching this video. I look forward to your feedback and comments. Please also remember to complete the consent form and either attach it to the email or copy it into the body of your email.

Also don't forget that the author of every feedback and consent form goes into the draw to receive a \$50.00 Westfield gift voucher.

Appendix 10: Phase Two Participant Information Sheet



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PARTICIPANT INFORMATION SHEET

PHASE TWO: EXPERT STAKEHOLDERS

TITLE

Interprofessional supervision: Mapping the interface between professional knowledge, practice imperatives and difference.

My name is Allyson Davys and I am currently undertaking a research study to fulfil the requirement of the degree of PhD in the School of Counselling, Human Services and Social Work at the University of Auckland.

The purpose of this study is to explore interprofessional supervision as a mode of supervision practice and to understand how the participants of interprofessional supervision construct and manage the supervision processes and relationships.

You are invited to contribute to *phase two* of this research on interprofessional supervision by agreeing to an interview to discuss your experiences and current practice of interprofessional supervision. The interview will be approximately 90 minutes in length and will be conducted in a location which is convenient to you.

To be eligible to participate you need to hold a graduate or post graduate professional supervision qualification and/or you need to be currently engaged in an interprofessional supervision relationship as either a supervisor or a supervisee.

ABOUT THE STUDY

I wish to explore the ways in which the participants of interprofessional supervision manage the processes of supervision, identify what skills they use and how they manage the interface of difference. For the purposes of this study interprofessional supervision is defined as being where the participants of supervision, the supervisor and the supervisee, do not share the same professional training or practice.

OVERVIEW OF THE STUDY

There are four phases to this research.

Phase one will identify the broad professional context in Aotearoa New Zealand within which interprofessional supervision is practiced.

Phase two will explore the experiences, attitudes and values of expert stakeholders and the skills and processes which are used in their practice of interprofessional supervision. These interviews will inform the development of a framework which describes the practice of interprofessional supervision.

The design of this research is sequential and participants in phase two are invited to also participate in stage three and stage four.

Phase three will explore the process of the practice of interprofessional supervision through direct observation of supervision in action. Following the interviews in phase two you will be invited to participate in phase three. Involvement in phase three will require the agreement of your 'interprofessional' supervisor or supervisee.

In phase four the preliminary findings from phases two (framework) and three (description of the supervision process) will be presented, through focus group(s), to volunteers from phase three. The participants will be invited to collaborate in the co-creation of a map for interprofessional supervision practice which is based on current practice.

If you are interested in joining phases three and four of the research I will discuss it further at the phase two interview or, if you wish, I can forward the information sheets in advance.

Inability, or disinclination, to be involved in phases three or four is not a barrier to participating in phase two (or three) of the research.

CONFIDENTIALTY

The material gathered from the interview with you will contribute to inform the development of a framework which describes interprofessional supervision. No material will personally identify you but broad demographics will be collected and include such things as participants' profession and practice experience. The interviews will be recorded using an audio recorder and should any identity be inadvertently revealed in these recordings it will be anonymised by the researcher. Professional assistance will be used to assist with transcribing the recordings. The transcriber will sign a form to agree to confidentiality and professional standards will be maintained.

Raw data and transcripts will only be seen by the researcher and transcriber. Should you wish to review the transcript to check the data and to ensure anonymity has been achieved I will forward you a copy at your request for this purpose. Any hard copy documents will be stored in a locked cupboard throughout the duration of the study and electronic files will be kept on a secure password protected computer. These files will be kept for six years and then destroyed.

RIGHTS

If you agree to take part in this research you will have the right to:

- Refuse to answer any question and to withdraw from the research at any time.
- Ask any further questions about the research at any time during your participation.
- Request that the audio recorder is turned off at any time.
- Provide information on the understanding that it is completely confidential to the researcher and that it will not be possible to identify you in any of the reports of the study.
- To be given access to a summary of the research findings when the research is completed.
- To be assured that all raw material including audio recordings will be kept in a secure place during, and on completion of, the research.

RESULTS

A summary of results will be available to be read by participants. The findings will also form the basis of academic papers which will be submitted to peer-reviewed journals with a view to publication.

Researcher:

Allyson Davys
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University of Auckland
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Main Supervisor: Associate Professor Christa Fouché Head of School Counselling, Human Services and Social Work Faculty of Education and Social Work University of Auckland 09 623 8899 ext 48648 c.fouche@auckland.ac.nz	Co Supervisor: Associate Professor Liz Beddoe Counselling, Human Services and Social Work Faculty of Education and Social Work University of Auckland 09 623 8899 ext 8559 e.beddoe@auckland.ac.nz
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APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS

Appendix 11: Phase Two Consent Form



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Interprofessional supervision: Mapping the interface between professional knowledge, practice imperatives and difference.

Consent Form.

Phase two – Expert Stakeholder Interviews

I,

being over the age of 16 years hereby consent to participate as requested in the interview for the research project on interprofessional supervision.

1. I have read the information sheet for phase two of this study
2. The details of the study have been explained to me.
3. My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any time.
4. I agree to the interview being recorded onto an audio recording device.
5. I am aware I should retain a copy of the Information Sheet and Consent Form for future reference.
6. I understand that:
 - a. I may not directly benefit from taking part in this research.
 - b. I am free to withdraw from the project at any time without disadvantage and to withdraw my data.
 - c. I am free to decline to answer any particular question(s) in the research.
 - d. I understand that I may request that the audio recorder be turned off at any time during the interview.
 - e. While the information gained in this research will be published and I understand that broad demographics will be collected and include such things as my profession and practice experience, I understand that I will not be personally identified and individual information will remain confidential.
 - f. I understand that I will be invited to participate in phase three of this research and that if I am unable or unwilling to do so it will not be a barrier to my participation in phase two.
 - g. I understand that this consent form will be kept for a period of six years.

I agree to participate in this research under the conditions set out in the information sheet.

I agree / do not agree to be recorded

I wish to review the transcript to check the data and to ensure anonymity has been achieved

Yes/No

PARTICIPANT'S SIGNATURE

Date

I certify that I have explained the study to the participant and consider that he/she understands what is involved and freely consents to participate.

Researcher: Allyson Davys

Signature

Date

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz.

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Appendix 12: Phase Three Consent Form



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Interprofessional supervision: Mapping the interface between professional knowledge, practice imperatives and difference.

Consent Form.

Phase three - Audio recording

I

being over the age of 16 years hereby consent to the digital audio recording of between one and three of my supervision sessions for the research project on interprofessional supervision.

1. I have read the information sheet for phase three of this study
2. The details of the study have been explained to me.
3. My questions about the study have been answered to my satisfaction and I understand that I may ask further questions at any time.
4. I agree to my supervision sessions being recorded onto an audio recording device.
5. I agree to ensure, to the best of my ability, that any references to another person (or persons) during the recorded session will be made in such a way as to protect his or her identity.
6. I am aware I should retain a copy of the Information Sheet and Consent Form for future reference.
7. I understand that:
 - a. I may not directly benefit from taking part in this research.
 - b. I am free to withdraw from the project at any time without disadvantage and to withdraw my data.
 - c. I am free to decline to answer any particular question(s) in the research.
 - d. I understand that I may request that the audio recorder be turned off at any time during the interview.
 - e. While the information gained in this research will be published and I understand that broad demographics will be collected and include such things as my profession and practice experience, I understand that I will not be personally identified and individual information will remain confidential.

- f. I understand that I will be invited to participate in phase four of this research and that if I am unable or unwilling to do so it will not be a barrier to my participation in phase three.
- g. I understand that this consent form will be kept for a period of six years.

I agree to participate in this research under the conditions set out in the information sheet.

I agree / do not agree to be recorded

I wish to review the transcript to check the data and to ensure anonymity has been achieved

Yes/No

PARTICIPANT'S SIGNATURE

Date

I certify that I have explained the study to the participant and consider that he/she understands what is involved and freely consents to participate.

Researcher: Allyson Davys

Signature

Date

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS

Appendix 13: Letter to Participate



**EDUCATION AND
SOCIAL WORK**

Epsom Campus

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Auckland, New Zealand
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W

www.education.auckland.ac.nz

The University of Auckland

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New Zealand

Interprofessional supervision: Mapping the interface between professional knowledge, practice imperatives and difference.

INVITATION TO PARTICIPATE

My name is Allyson Davys and I am currently undertaking a research study to fulfil the requirement of the degree of PhD in the School of Counselling, Human Services and Social Work at the University of Auckland.

The purpose of my study is to explore interprofessional supervision as a mode of supervision practice. I want to understand how the participants of interprofessional supervision manage the supervision structures and relationships and what skills and processes are employed in the practice of interprofessional supervision. I am interested in how the interface of difference between professions is managed.

Your supervision partner has participated in the second phase of the research and is interested to participate in phase three. Phase three involves the recording and analysis of actual supervision sessions between practitioners from different professions and requires the participation of his or her supervision partner.

I am writing to invite you to join phase three of the research.

Your supervision partner will be talking to you about this project and this letter is to provide you with some background information and also to give you the opportunity to contact me if you have any questions or concerns.

In 2016 I will hold a part time teaching position at the University of Auckland on the post graduate professional supervision programme. If by any chance you are a student on that supervision programme please be assured that I will not participate in any assessment of your work.

Attached please find a Participant Information Sheet and a Consent Form relating to phase three of the research project. I am very happy for you to contact me regarding this project and I am happy to come and meet with you individually or with both you and your supervision partner.

Allyson Davys

Researcher:

Allyson Davys
Counselling, Human Services and Social Work
Faculty of Education and Social Work
University of Auckland
027 224 4590
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Main Supervisor: Associate Professor Christa Fouché Head of School Counselling, Human Services and Social Work Faculty of Education and Social Work University of Auckland 09 623 8899 ext 48648 c.fouche@auckland.ac.nz	Co Supervisor: Associate Professor Liz Beddoe Counselling, Human Services and Social Work Faculty of Education and Social Work University of Auckland 09 623 8899 ext 8559 e.beddoe@auckland.ac.nz
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For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS

Appendix 14: Transcriber Confidentiality Agreement



**EDUCATION AND
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TRANSCRIBER CONFIDENTIALITY AGREEMENT

Interprofessional supervision: Mapping the interface between professional knowledge, practice imperatives and difference.

Iunderstand that I have been engaged to transcribe digitally recorded confidential material for the purposes of research.

I agree to maintain confidentiality and not to discuss or divulge any material from the recordings other than to the researcher. I will keep all digital recordings and printed transcripts in a secure and private place during the course of the project. All material will be returned to the researcher at the end of the project.

Signature Transcriber

Date

Signature Researcher

Date

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 ext. 83711. Email: ro-ethics@auckland.ac.nz.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS

Appendix 15: A Map for Interprofessional Supervision

A Map for Interprofessional Supervision

“A supervisee is “one who brings his/her work to another (individual or group) in order to learn to do that work better” (Carroll & Gilbert, 2011, p. 15).

Interprofessional supervision is where the participants of supervision, the supervisor and the supervisee, do not share the same professional training or practice. The participants in an interprofessional supervision relationship may be health, psychological or social service practitioners, may belong to a profession such as education, human relations or the clergy, or may work in an occupation or in the non-regulated workforce where there is a relational dynamic.

The map presented here is a guide to assist those engaged, or those wishing to engage, in interprofessional supervision to navigate the territory and to find a pathway to effective interprofessional supervision which best suits their situation. The map presents five components. Component one defines the *ideal prerequisites* for engagement in interprofessional supervision and encircles the other four components. It identifies the importance of supervision knowledge, training and competence and recognises the value of the practice or professional experience which each person brings to the relationship. Components two, three and four (*qualities, relationship* and the *supervision session*) comprise the core of interprofessional supervision and sit within component one. Though separate these three components are inter-connected. The qualities brought by the participants contribute to the development of the relationship which in turn affects the activity of supervision within the supervision session. Positioned alongside the supervision session is the fifth component, *other professional relationships*. This component recognises that professional accountability, professional knowledge, support, emotional resourcing and professional development do not reside in any one relationship. *Other professional relationships* validates the importance of a range of different and necessary relationships which support and supplement interprofessional supervision.

Carroll, M., and Gilbert, M. (2011). *On Being a Supervisee: Creating Learning Partnerships* (2 ed.). Australia: Psychoz.

1: Ideal Prerequisites

Supervision training and knowledge:

This is regarded as essential for supervisors and important for the supervisees who access supervision.

Experience:

Practice experience is regarded as important for both supervisors and supervisees. It is however recognised that this is not always the reality of practice for supervisees.

2: Qualities

Supervisors & supervisees in interprofessional supervision both need to demonstrate:

authenticity, openness, curiosity, empathy, respect, confidence, courage, humility, mutuality, reliability, professional relativity, willingness to learn and appreciation of diversity, an ability to sit in the mode of 'not knowing'.

3: The Relationship

Choice:

The ability, or the freedom, for both supervisor and supervisee to choose whether to engage in a particular supervision relationship is important.

Fit:

An initial meeting between the supervisor and the supervisee is important to determine whether the relationship has the potential to meet the supervisee's needs and for both parties to determine whether there is an appropriate 'fit' of expectations, skills values and personality.

Negotiation:

The supervision agreement/contract and the discussion, disclosure and negotiation which accompany it are critical. The contracting process acknowledges and clarifies: the expectations and parameters of supervision, the limitations and boundaries of knowledge, difference, and the strategies to address difference, power and its impact on the relationship, the supervisee's accountability to his or her own profession and clinical practice, and how and when the supervision relationship and process will be reviewed. The process of

negotiating the interprofessional supervision agreement/contract contributes to the building of trust between the two parties.

4: The Interprofessional Supervision Session

Structure:

Interprofessional supervision creates a space, or a learning place, where the supervisee can safely and honestly reflect and where his or her professional development and professional growth are supported.

There is a focus on the processes of practice, the structures and systems of practice, the supervisees' self-management, self-care, relationship-management and professional identity.

Topics for discussion are led by the supervisee and facilitated by the supervisor.

Very importantly, supervision is driven through knowledge of *supervision* practice as opposed to *profession specific* practice.

Process:

The responsibility to ensure that relevant professional accountability and professional responsibilities are covered for the supervisee is *shared* between supervisor and supervisee.

Supervision is a collaboration between both parties where curiosity, openness, tolerance of 'not knowing' and a range of questions assist in avoiding the trap, and danger, of making assumptions.

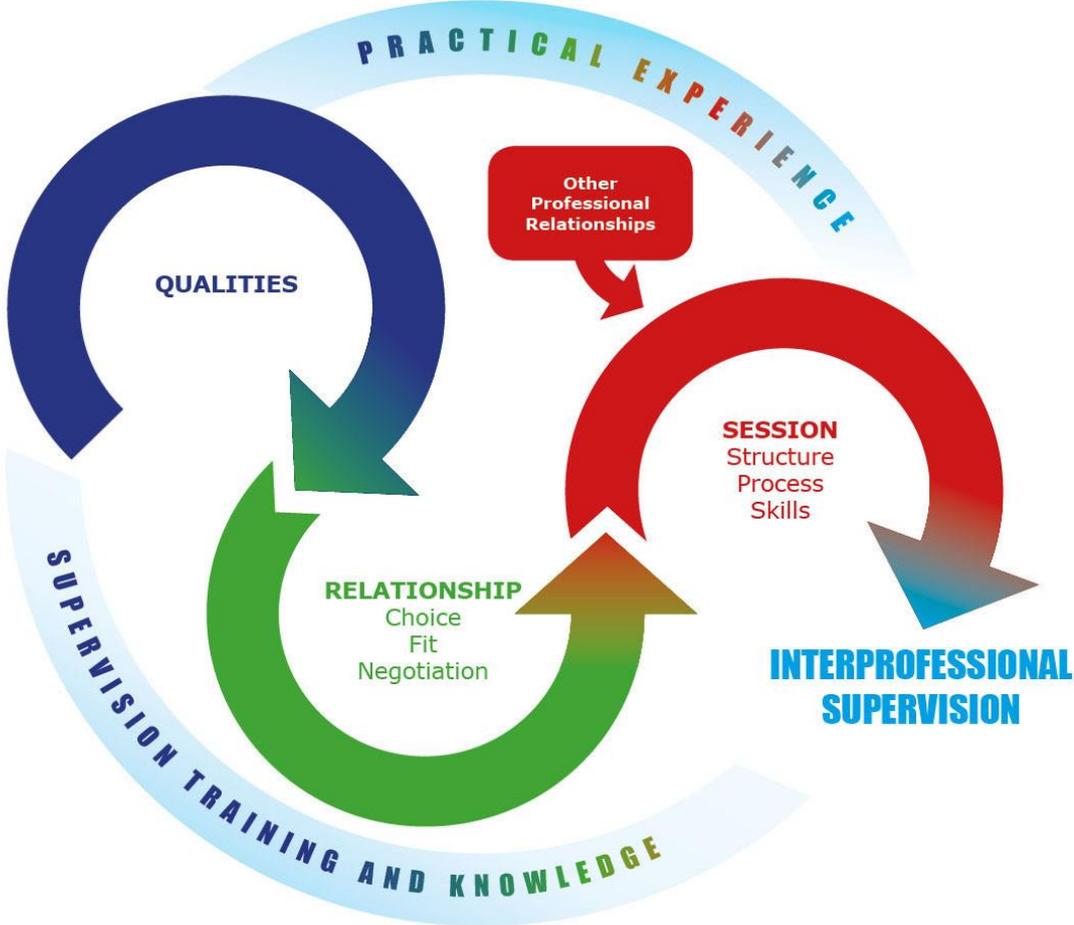
Skills:

A range of skills and interventions are used by the supervisor with particular emphasis on: open reflective enquiry, challenge, attentive listening, paraphrasing, summarising, affirmation, feedback, reframing, management of power and difference (intersectionality).

5: Other professional relationships

Many supervisees also access alternative forms of professional relationships, which supplement interprofessional supervision or address areas not covered in interprofessional supervision. In particular: clinical same-profession supervision, peer or collegial support, consultation and/or management supervision/accountability for profession-specific practice.

A Map for Interprofessional Supervision



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