Occupational Therapy Board of New Zealand

TE POARI WHAKAORA NGANGAHAU O AOTEAROA

FOSTERING FAITH AND CONFIDENCE IN THE PROFESSION

The Occupational Therapy Board of New Zealand's use of professional supervision as a condition on scope of practice

A research project carried out by OTBNZ

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Executive summary

Since the introduction of the Health Practitioners Competence Assurance Act in 2003, the Occupational Therapy Board of New Zealand (OTBNZ) has used mandatory periods of supervision as a regulatory tool to mitigate risk posed to the public. The main groups of practitioners who have this condition on their scope of practice are occupational therapists who are new graduated, overseas qualified or returning to practice. An extensive review of regulators of occupational therapy and other domestic health and education regulators found that mandated supervision was standard regulatory practice in Aotearoa New Zealand and internationally. Despite this widespread use of supervision, there is little research or literature that has investigated the implications of using supervision in this way.

What research is emerging in the health-related regulatory literature pertains to risk factors of the likelihood of receiving unsafe practice from a health practitioner. The risk factors that are emerging from these studies show that receiving a previous complaint, male gender and older age increase the likelihood of receiving a practice-related complaint, although variation between professions occurs. In the wider literature, there is a plethora of research about supervision as a practice. Within this, there is a growing concern about the harmful effects of unsafe supervision for practitioners.

To provide information about the outcome and use of supervision as a standard condition, data held by OTBNZ was collated and analysed. The research found that a significant number of practitioners continued to have a condition remaining on their scope of practice past the mandatory period. Of these, practitioners with a return to practice or overseas condition were more likely to have an overdue condition. These findings were supplemented with a qualitative survey about supervision with practitioners who had successfully completed the process to remove a condition on their scope of practice. In this survey, both supervisees and supervisors rated their supervision experience highly. They strongly supported an increase of flexibility and individualisation of the use of supervision according to the need of the practitioner involved. The survey also showed that there remained a high incidence of line managers providing supervision and that 50% of supervisees had no choice of supervisor. Another significant finding was a mismatch between what supervisors and supervisees prioritised as important content to address within supervision. One of these mismatches was the prioritisation of cultural competence, which supervisees' rated significantly more highly than supervisors.

Another finding of the research was the use of terminology by other regulators in Aotearoa New Zealand. The term "condition on scope of practice" is used by other health regulators more generally to describe practitioners with specific competence or fitness issues. OTBNZ's use of "standard condition on scope of practice" carries a risk of potentially confusing employers and the public because it may be interpreted as having a different meaning than intended.

Introduction

The Occupational Therapy Board of New Zealand (OTBNZ) was established after the enactment of the Occupational Therapy Act 1949. Since then, OTBNZ has been responsible for regulating the profession of occupational therapy. After considerable legislative reform, the Health Practitioners Competence Assurance Act 2003 (HPCA Act)[1] has superseded the original Occupational Therapy Act and its amendments.

The HPCA Act introduced many new responsibilities and functions that responsible authorities were required to comply with in order to provide a greater assurance to the public that registered health practitioners were safe and competent to practise. OTBNZ elected to use professional supervision as a mandatory requirement to fulfil some of these new regulatory responsibilities.

From 2004, a mandated condition of supervision from an occupational therapist with a current practising certificate who had no conditions on their own scope of practice was placed on the scope of practice for new graduates, those returning to practice and overseas-qualified practitioners (Table 1). The mandated conditions below have remained in place since this time.

Table 1: Supervisory requirements for new graduates, those returning to practice and overseas-qualified practitioners.

Condition	Supervisory requirement
New graduate	Weekly supervision for the first 12 months of practice
Return to practice in New Zealand[2]	Fortnightly supervision for the first 6 months of practice
Overseas-qualified registrant	Fortnightly supervision for the first 6 months of practice

To provide some numerical context, in the 2017/18 practising year, of the total 3,617 registered practitioners, 14% (506) held a condition on their scope of practice. During that year, OTBNZ registered 181 new graduates, 58 overseas-qualified practitioners and 35 returning practitioners (OTBNZ, 2018). OTBNZ also applied personalised conditions on the scope of practice to a small number of practitioners for requirements that fell outside the standard conditions (such as competence, conduct or health reasons).[3]

In relation to the workforce, overseas-qualified practitioners make up a significant proportion of practising occupational therapists – nearly a quarter (21%) of the practitioners holding a practising certificate in this period.

As a regulatory tool, supervision is on a continuum that also includes legislative actions such as appointing a professional conduct committee to investigate a complaint, directing an individual competence review or, in exceptional circumstances, suspension of a license to practise. To assist OTBNZ in ensuring the right level of regulatory intervention using the right tool, OTBNZ has adopted an UK based 'right-touch regulation' model. Right-touch regulation was introduced by the Professional Standards Authority in the United Kingdom.[4] It advocates for the regulatory response being proportional to the level of risk posed, as well as a continual evaluation of the regulatory tools deployed.

To evaluate the risks posed by the three groups of practitioners to which the standard condition of supervision is applied, current literature and information about complaints related to health practitioners were reviewed.

[1] The principal purpose of this 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.

[2] This condition applies to practitioners who have been away from practice in Aotearoa New Zealand for more than 3 years unless they have applied via the Trans-Tasman Mutual Recognition Agreement.

[3] The application of personalised conditions is not included in this investigation.

[4] The Professional Standards Authority is an independent body that oversees the operations of the Regulatory Authorities in the United Kingdom – see www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation.

Literature review

Evaluating risks related to health practitioners and health professions is an emerging field of research. Within this limited field, there is even less direct research that has examined occupational therapists. The research that is available tends to focus on the larger health professions such as medical doctors and dentists, which have larger public profiles, with smaller professions grouped together into one statistical category or only some professions receiving research attention.

For example, a recent American study involved complaints related to the dental professions. The study found being of male gender was a higher risk of receiving a complaint and that 49% of the complaints involved the same practitioners (Thomas et al., 2018). The high incidence of the same practitioners generating many of the complaints for a profession supported an earlier American study investigating the complaints against doctors of medicine and osteopathic medicine. In this study, 32% of complaints involved the same practitioners (Studdert et al., 2016). Another finding of this study was that the speciality of the doctor was a predictor of higher complaint levels. In the allied health professions, an Australian research project has analysed data related to chiropractors, physiotherapists and osteopaths. This study found that male gender, age over 65 and working in a metropolitan area were factors that placed practitioners at a higher risk of receiving a complaint about their service. With further analysis and statistical benchmarking, the study found that chiropractors received the most complaints, with 36% of these related to the same practitioners (Ryan, San Too & Bismark, 2018).

In Aotearoa New Zealand, a report from the Health and Disability Commissioner (HDC) related to medical doctors in 2017 supported these findings. It also found male gender, working in particular specialities and having practised between 21 and 30 years were predictive factors for medical doctors receiving a complaint about their practice (King & Davidson, 2017). This finding does not appear to be generalisable to the overall health workforce. In an earlier analysis of Health Practitioner Disciplinary Tribunal outcomes since the advent of the HPCA Act, 63% of the cases involved a female practitioner, which is largely consistent with the makeup of the overall workforce (Surgenor, Diesfeld, Ip & Kersey, 2016).

The HDC recently supplied data to Parliament's Health Select Committee[5] that showed the recent level of complaints about occupational therapists referred to the HDC was comparable or lower than other health professions (Table 2).

Table 2: Data on complaints referred to HDC each year by regulatory authorities.

	2015/16	2016/17	2017/18 YTD (at 28/05/2018)
Chiropractic Board	4	3	4
Dental Council	9	7	2
Dietitians Board	0	0	1
Medical Council	19	18	22
Medical Sciences Council	0	0	2
Medical Radiation Technologists Board	0	0	0
Midwifery Council	12	12	13
Nursing Council	18	32	30
Occupational Therapy Board	3	1	0
Optometrists and Dispensing Opticians Board	2	2	2
Osteopathic Council	2	0	0
Pharmacy Council	1	1	2
Physiotherapy Board	11	22	9
Podiatrists Board	2	2	0
Psychologists Board	29	18	21
Psychotherapists Board	No record	No record	No record
Social Workers Registration Board	2	0	3
TOTAL	114	118	111

From this data, occupational therapists appear to be at equal or lower risk of complaints as compared to the similarly registered and numbered psychologists, midwives and physiotherapists. The demographics of occupational therapy in Aotearoa New Zealand (90% female, median age 40 years and no incidents of repeated disciplinary action since the HDC was formed) tends to place it outside of the risk profile emerging from the overseas literature (older age, male and

[5] www.parliament.nz/resource/en-NZ/52SCHE_ADV_76354_4727/529e03a294671beffbc1824b7fa0fd58de77cba8

received a complaint previously). The low number of complaints also suggests that the current use of supervision by OTBNZ is effective in providing safe occupational therapy to the public.

From this brief review of the literature and available data, there appears limited evidence to support the traditional view that overseas-qualified or returning practitioners or new graduate occupational therapists present a risk to the public. Despite this, it is standard practice for most regulators to consider these groups of practitioners as a higher risk for public safety. In Aotearoa New Zealand, overseas-qualified, returning and new graduate practitioners are required by OTBNZ to receive mandated supervision as one of the main regulatory strategies to ensure they are safe to practise. Right-touch regulation principles require that the level of intervention is proportional to the risk posed. For this reason, the use of mandatory supervision as a regulatory tool required review to ensure it is the right touch for the risk posed as well as an appropriate tool to protect the public.

Supervision as a regulatory tool

Supervision is a professional activity that occupational therapists in Aotearoa New Zealand and elsewhere have long supported as being a valuable and necessary component of their everyday practice (Wimpenny et al., 2006; Herkt & Hocking, 2007; Simmons Carlsson & Herkt, 2012). By using supervision as a regulatory tool, OTBNZ extended a normalised practice into a regulatory activity, capitalising on the way this practice was an already sanctioned professional behaviour. Supervision has become a normalised practice for occupational therapists as a quality and safety strategy (Fitzpatrick, Smith & Wilding, 2015; Roberts, Fitzgerald & Molineux, 2017) but the effectiveness of it to mitigate risk to the public remains unclear. The research that has examined the practice of supervision in occupational therapy contains indications that supervision as it is currently practised in Aotearoa New Zealand does present risks. These risks are to the practitioner and, by default, the public due to the practitioner not being supervised effectively.

Occupational therapy-specific research includes two serial articles by Jacqui Herkt and Clare Hocking who suggested that mandatory supervision can impact on supervisees' disclosure of competence issues due to not wanting to jeopardise the removing of the condition or their registration status (Herkt & Hocking 2007; 2010). These researchers also suggested that the supervision process provided to occupational therapists in Aotearoa New Zealand varies in quality and is not always experienced as supportive or effective. One of the possible reasons for this was the finding that the occupational therapists who participated in their research commonly received supervision from line managers. This has the effect of linking supervision to the employee/employer relationship due to the connections the line manager has to remuneration, performance appraisals, accessing ongoing training, clinical roles and promotions (Herkt & Hocking, 2007). The researchers also concluded that supervision often does not involve the normal day-to-day practices related to a therapist's caseload (Herkt & Hocking 2010). This finding raises questions about how supervision is influencing day-to-day practices and competence.

Shortly after these publications, OTBNZ commissioned a review to "provide clarity around the different types of supervision and better consistency in the wording in the various Board documents that refer to supervision" (Simmons Carlsson & Herkt, 2012, p.3). The subsequent report detailed several recommendations and suggested that:

> Whilst there is general consensus within the profession about the purpose, scope, and benefits of supervision and that supervision is primarily centred on reflective practice processes, misunderstanding and misinterpretation is evident regarding the latter two types [mandatory supervision required as part of the competency requirements of the ePortfolio and supervision as a condition of scope of practice] of supervision (Simmons Carlsson & Herkt, 2012, p.3).

Outside the occupational therapy profession, there have been recent publications pertaining to other allied professions in Aotearoa New Zealand that report similar findings and recommendations related to supervision practices. In a wide-ranging study involving counsellors, mental health nurses, psychologists and social workers, Davys, O'Connell, May and Burns (2017) found that many of the participants had simultaneous supervisory, managerial and supervisee roles within their organisations. Another article generated from the same research project reported on the social work cohort specifically and found that the supervision of social workers was commonly provided by team leaders or line managers. This project also found that a third of supervisors operated in a system where outcomes of the supervision could be accessed by managers. Several supervisees commented that they had accessed or enquired about accessing and paying for external supervision to avoid the 'toxic' in-house

supervision environment created by this situation (Davys, May, Burns & O'Connell, 2017).

Internationally, similar concerns about power relations within supervision exist. The dual role of supervisor and manager was identified as problematic for some supervisees for similar reasons in an Australian investigation about supervisory practices in occupational therapy (Roberts, Fitzgerald & Molineux, 2017). In another study involving rehabilitation counsellors, a concern was articulated about supervisors engaging in well-intentioned but unethical behaviour towards their supervisees. The authors attribute this to a lack of training in supervision, stating "supervisors require training to understand their own ethical responsibilities as supervisor, as well as how to facilitate the ethical development of the supervisee" (Landon & Shultz, 2018, p. 25). The lack of training of supervisors or practitioners supervising other practitioners before they have enough experience was also been highlighted by other authors from the social work profession (Beddoe, 2017) and psychology (Ellis et al., 2014; Reiser & Milne, 2016).

Beddoe (2017) provided further nuance to these findings that relates to the bicultural context of occupational therapy practice in Aotearoa New Zealand. Beddoe carried out a thematic critique of narratives recounting harmful supervision and found that race and gender were the most frequently cited reasons for negative experiences of supervision. The specific reasons identified in the narratives were "personal difficulties as a visible minority; negative personal attributes of the supervisor; lack of a safe and trusting relationship; lack of multicultural supervision competencies; and lack of supervision competencies" (Beddoe, 2017, p. 93). The theme of culturally safe and appropriate supervision was also commented on strongly by the Aotearoa New Zealand social workers who participated in Davys et al.'s research. Evaluating whether cultural needs were being met along with the respect for culture and difference were recommended to be part of supervision practice. If the supervisor could not provide this, external resources should be made available to ensure it happens (Davys, May, Burns and O'Connell, 2017, p.114).

As indicated by this brief review of the literature, a conversation about the practice of supervision in occupational therapy and other professions in Aotearoa New Zealand has been going on for some time. OTBNZ has responded to some of these critiques and recommendations by providing further advice and expectations about supervision. A supervision guideline and fact sheet have been produced (OTBNZ, 2015, 2016) and OTBNZ-specific documentation such as supervision logs and supervisors report templates specified.[6] Behind this, however, is the assumption that supervision is an appropriate regulatory tool to ensure that the public receives safe occupational therapy.

In the wider context, how supervision ensures practitioners are providing appropriate care, the use of health resources (time and money) spent on supervision, how supervision can support bicultural practice are all additional questions that flow from this assumption. Other unintended consequences such as contributing to the regulatory burden of practitioners, creating barriers for returning to practice and harm to practitioners from unsafe supervisory relationships are also risks associated with mandatory supervision.

This research project has sought to provide additional information about the use of mandated supervision to protect the public when receiving occupational therapy and guide the right touch of policy and processes when using supervision for this end.

Research approach

To investigate the effectiveness of mandatory supervision, OTBNZ commissioned a review of the use of supervision as a regulatory tool by (then) external contractor Dr Mary Silcock. After this review, detailed operational research and an online survey about supervision practices of occupational therapists who held practising certificates was conducted by OTBNZ's Standard, Policy and Risk Advisor Dr Megan Kenning. These two projects have been combined into this report and have provided comparative information as well as micro-level operational data about the use of supervision as a standard condition on scope of practice.

[6] https://www.otboard.org.nz/documents/supervision-competence-fitness/

The use of supervision as a regulatory tool – international practice

A desktop comparison of regulatory practices for occupational therapists in Australia, United Kingdom, Ireland, two provinces of Canada and two states of North America was carried out. These countries were chosen because of their similarity in how occupational therapy is practised and the established links Aotearoa New Zealand has with these countries. Due to the federal structures of government in Canada and America, two representative Occupational Therapy Boards (a rural/low-density population and an urban/high-density population) were chosen to provide some form of representation of how these large countries regulate. To drill down to find out how the boards carried out these regulatory functions, particularly in relation to supervision as a standard condition on scope of practice, publicly available documents (policies, processes, legislations, manuals and position statements) in relation to new graduates, those returning to practice and overseas applicants were reviewed and summarised in Table 3.

Findings

All the occupational therapy regulators reviewed were part of legislative structures to ensure public safety when receiving health-related services. The regulators all provided services similar to OTBNZ such as administering national examinations, assessing overseas applicants, conducting audits, oversight of health regulation and developing policy advice for health regulation to government and other stakeholders. They each had an appointed or elected board that mainly comprised of occupational therapists along with a public register and some form of competence programme. The use of supervision as a regulatory tool as an operational part of these functions varied considerably between countries.

Only two of the regulators – Australia and the Saskatchewan province of Canada – had detailed formal supervision guidelines. Both guidelines were written for the mandated mentoring or supervision required in order to remove conditions on scopes of practice.

The Saskatchewan Society of Occupational Therapists (SSOT) had very detailed specifications of what supervision should entail. The supervisor (referred to as a mentor) was required to:

> … identify the selected member's strengths, performance, and challenges as they relate to the development of their Professional Development Plan and Outcomes (PDPO) by using the Self-Assessment Tool; assist in planning strategies to bridge gaps in the learning process; providing support, guidance and encouragement as the selected member develops their PDPO and compiles their evidence; acting as a facilitator or mentor while the selected member takes the actions necessary to achieve his/her goals; provide a written report to the Professional Practice Committee on the selected member's progress using the SSOT Restricted License Level II Process as a guide. (SSOT, 2013, p. 7)

The Occupational Therapy Board of Australia (OTBA) has a 51-page supervision guideline for use with practitioners returning to practice after an absence of 5 or more years, overseas-qualified practitioners, practitioners who have a condition on their registration or who have entered into an undertaking that requires supervision and practitioners who hold a type of limited registration where supervision is a requirement of registration. The guidelines are specifically not for the supervision of students, the mentoring of new graduates or more junior practitioners or supervision for professional development purposes (OTBA, 2014, p. 2)

The other occupational therapy boards had minimal or no reference to what supervision should entail on their websites. The UK's Health and Care Professions Council (HCPC) briefly refers to supervision in its standards of proficiency for occupational therapists: "the importance of participation in training, supervision and mentoring" (HCPC, 2013, p. 8) and recognising "the value of case conferences, supervision and other methods of reflecting on and reviewing practice" (HCPC, 2013, p. 11).

The province of British Columbia in Canada appears to take an even more distanced approach. The College of Occupational Therapists of British Columbia (COTBC) it mentions supervision only once and emphasises the individualised nature of supervision by stating: "Supervision does not necessarily involve monitoring every practice step the provisional registrant takes in the provision of occupational therapy services. The full registrant practice supervisor must provide guidance and feedback commensurate with the provisional registrant's skills and experience." (COTBC, 2016, p. 1). The remaining occupational therapy regulators that

were reviewed – Ireland,[7] Iowa and California – made no reference at all to what supervision should entail on their websites.Supervision logs, records, contracts or agreements were only referred to by OTBNZ (2016) and the Occupational Therapy Council (Australia & NZ) Ltd (2017).

All boards expected a formal supervisor's report to lift the condition of mandatory supervision. All boards also had similar expectations of who could be a supervisor. These were that supervisors needed to be on the board's register, have at least 1 year of experience and not have any conditions on their own registration or scope of practice. The SSOT was the only board that required specific training for mentors and matched supervisees with these mentors to meet their supervision conditions (SSOT, 2013).

[7] Ireland has only recently formed its occupational therapy board in 2015 and is still in a transition period, which may be why there are few profession-specific documents publicly available yet.

Table 3: International occupational therapy regulatory practices (as at March 2017).

Regulatory authority	New graduate conditions	Returning to practice conditions	Overseas applicant conditions
OTBNZ • 2,500 OTs registered	• Approved qualification. • Weekly supervision for 12 months. • Written report from supervisor.	• After 3+ years no APC. • Fortnightly supervision for 6 months. • Written report from supervisor.	• Fortnightly supervision for 6 months. • Written report from supervisor. • Completion of an online Foundation course in cultural competency (Māori)
HCPC (UK) • 16 professions • 37,749 OTs registered • Overseen by Professional Standards Authority	• No supervision conditions	• 2–5 years no APC – 30 days of updating. • 5+ years – 60 days of updating. • The updating period can comprise a combination of supervised practice, formal study and private study. A summary of the activities that have been undertaken, including the number of days spent on each area, needs to be provided and countersigned by a health and care professional from same part of the register to confirm that the information is correct. (HCPC, 2017)	• Individually assessed by registration officer against standards of proficiency for all occupational therapists. Does not state that supervision is a standard condition. (HCPC, 2013)
OTBA (Australia) • 18,444 OTs registered • AHPRA oversees 15 professions	• No supervision conditions “but it’s a good idea as receiving supervision is an important development tool”.[8]	• After 5+ years no APC. • 30 hours of continuing professional development completed in the 12-month period prior to applying for re-registration. • Provisional registration while undertaking a period of supervised practice required by the board. The period of supervised practice will be not less than 3 months full-time equivalent, with a supervisor assessment against the Australian Minimum Competency Standards for New Graduate Occupational Therapists.(OTBA, 2014)	• Initial assessment in compliance with the requirements specified by the Occupational Therapy Council (OTC). This assessment comprises Stage 1 – desktop audit, Stage 2 – supervised practice audit. • As a minimum, it is expected the supervisor provides 1 hour of weekly face-to-face supervision with the practitioner for the first 6 weeks to support the implementation of the supervised practice plan and to observe practice to

[8] https://www.occupationaltherapyboard.gov.au/codes-guidelines/faq/information-for-students.aspx

Regulatory authority	New graduate conditions	Returning to practice conditions	Overseas applicant conditions
			assess competence. • The frequency of supervision could then be modified to at least fortnightly until the completion of the supervised practice period. • Practitioners are required to maintain a signed log of supervision received. This document should be submitted with the midway report and the final report at the conclusion of the period of supervised practice. • In order for the period of supervised practice to be considered completed successfully, the practitioner must have completed a minimum of 3 months' full-time equivalent practice and the supervisor must have assessed the practitioner as competent in all identified areas on the supervised practice plan. • The practitioner will send the final reports and supervision log to the OTC for review. Upon successful assessment by the OTC, a certificate of practical completion will be issued, and the OTC will advise AHPRA of the certificate number. (Occupational Therapy Council (Australia & NZ) Ltd, 2017) • Supervised practice plan must include an orientation or introduction to the Australian healthcare system. An orientation report template can be found at Appendix 5. (OTBA, 2014)

Regulatory authority	New graduate conditions	Returning to practice conditions	Overseas applicant conditions
COTBC (Canada) • 4.7 million population • 2,380 registrants (76 non-practising) • Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO) recently formed to co-ordinate the 10 provincial Canadian regulators	• Provisional registration and supervised practice until passed national examination. • Employer acknowledgement of supervision form sent to COTBC. "This assures us (and ultimately the public) that your employer understands that you need a practice supervisor until you've written and passed the NOTCE [examination]". (COTBC, 2016)	• Must have worked at least 1,000 hours in the immediate past 5 years or at least 600 hours in the immediate past 3 years or have completed an approved re-entry programme in the past 18 months or do not meet any of the above currency requirements and require a review.	• All overseas applicants assessed through ACOTRO using the Substantial Equivalency Assessment System (SEAS), a multi-part assessment that determines if education and competency is substantially equivalent to those of occupational therapists educated in Canada. • Follow provisional registration process until passed National Occupational Therapy Certification Exam (NOTCE).
SSOT(Canada) • 1.3 million population	• New graduates generally graded as a level 2 restricted license member until they pass the national exam. • Conditions for restricted license members – reports regarding the practice abilities of the level 2 restricted license Member shall be sent every 2 months to the Credentials Committee contact person. • Supervision requirements – face-to-face contact with the restricted license member according to the minimum requirements of the following schedule: • Level 1 restricted license – as determined on case-by-case basis by Credentials Committee. • Level 2 restricted license – within the first 5 days of employment of the restricted	• Worked 1,000 hours in the last 5 years or 600 hours in the last 3 years in a regulated province or country. • SSOT re-entry program follows restricted license process (SSOT, 2010)	• All overseas applicants assessed through ACOTRO using the Substantial Equivalency Assessment System, (SEAS), a multi-part assessment that determines if education and competency is substantially equivalent to those of occupational therapists educated in Canada. • Individually reviewed by committee

Regulatory authority	New graduate conditions	Returning to practice conditions	Overseas applicant conditions
	license member, once a week for the first month, once every 2 weeks after the first month until successful passing of the CAOT certification examination. • Level 3 restricted license – within the first 30 days of a restricted license member receiving a level 3 restricted license, as needed during the course of the restricted license. (SSOT, 2010)		
Iowa Board of Physical and Occupational Therapy • Part of Iowa Department of Public Health • 3.1 million population • National Board for Certification of Occupational Therapy (NBCOT) sets examination for all 50 states, Guam, Puerto Rico and the District of Columbia	• Limited permit holder until passed national examination. • Until then practice only under the supervision of an Iowa-licensed OT for a period not to exceed 6 months.	• 2–5 years no license, 30 hours CPD. • After 5+ years no license, 60 hours CPD. • Or passing national exam within 1 year prior to the submission of an application for reactivation. (Iowa Board of Physical and Occupational Therapy, n.d)	• Internationally educated occupational therapists must meet NBCOT eligibility requirements and undergo pre-screening based on the status of their occupational therapy educational programmes. (Iowa Board of Physical and Occupational Therapy, n.d.) • NBCOT administers eligibility screening and the NBCOT certification exam.

Regulatory authority	New graduate conditions	Returning to practice conditions	Overseas applicant conditions
California Board of Occupational Therapists • Part of Department of Consumer Affairs • 38.8 million population • National Board for Certification of Occupational Therapy (NBCOT) sets examination for all 50 states, Guam, Puerto Rico and the District of Columbia	• All OT limited permit holders must practise under the supervision of an OT licensed by the Board pursuant to Title 16, California Code of Regulations, Section 4183.9 • This supervision must be "periodic" which is legally defined as once every 30 days.[10]	• >5 years held a license – complete 40 hours continuing education (or professional development units) within the past 2 years or pass the NBCOT examination. • 5+ years no license – shall submit evidence of meeting the continuing competency requirements by having completed, during the 2-year period immediately preceding the application, 37 professional development units (PDUs) directly related to the delivery of occupational therapy services and 3 PDUs related to ethical standards of practice in occupational therapy.[11]	• OTs trained outside of the United States are required to complete the educational and supervised fieldwork requirements set forth in the Occupational Therapy Practice Act (OTPA) section 2570.6 and successfully complete the entry-level certification examination administered by NBCOT.
Health and Social Care Council (Ireland) • 13 professions • 4.5 million population	• No supervision conditions.	• Individually assessed. • May be subject to other requirements if more than 2 years since last practised.	• Individually assessed if meet approved qualifications and competence. • Registration Board can decide that there is a deficit in the qualification meeting some of the essential criteria and offer a compensation measure. (Does not expand on what a compensation measure is).

[9] http://www.bot.ca.gov/applicants/limited_permits.shtml
[10] http://www.bot.ca.gov/board_activity/laws_regs/cc_regulations.shtml#4180
[11] http://www.bot.ca.gov/applicants/application.shtml

Supervision as a regulatory tool in Aotearoa New Zealand

The practices of health regulators for physiotherapy, psychology, dietitians, nursing and midwifery were also reviewed and summarised in Table 4. These professions were chosen because they practise in similar settings to occupational therapy. A significant proportion of practitioners work in the public sector/DHBs with the rest in a multitude of non-government and private enterprise. To provide a comparison with a different regulatory sector, the profession of teaching was also reviewed. All these regulatory bodies had boards that operated in a similar way to OTBNZ. The boards' public documents all reflected the legal requirements directed by the HPCA Act and, for the Education Council, the Education Act 1989. A wide variety of practices that incorporated mandatory supervision on scope of practice were used by all these regulators.

Findings

New graduates

Physiotherapy and nursing do not use supervision as a condition on new graduates' scope of practice. Nursing new graduates can choose (or apply to be part of) highly structured programmes based at DHBs, but these are not mandatory.[12] Psychology, midwifery, dietetics and teaching do use supervision as a condition on scope of practice for new graduates. The supervision is expected as a number of hours (1,500 for psychologists), a length of time (2 years for teachers, 1 year for midwives) or to the satisfaction of board-appointed mentors (midwives). These professions also have clear delineation of the status of a new graduate with specific titles such as provisional (midwives, teachers), intern or trainee (psychology). Dietitians have a process very similar to occupational therapy, with 1 year of supervision required for new graduates and a supervisor's report necessary to remove the condition. The frequency of supervision is directed by the three health regulatory boards – psychologists (2 hours per month), dietitians (fortnightly for six months) and midwives (6 weekly for 1 year).

Return to practice

Returning to practice processes also vary. If a practitioner is returning after 3–5 years of non-practice, all boards except nursing involve a period of formal supervision. Physiotherapy requires 3–6 months, psychologists 1 year, dietitians 15 months, midwives a minimum of 1 year and teachers have to pass a 20-day practicum. Teachers, midwives and dietitians all require completion of specified re-entry training courses in conjunction with this. These courses are offered by their professional associations or tertiary providers such as polytechnics, large private hospitals (e.g. Bupa) or universities. Returning midwives are required to pay a board-approved mentor to observe their practice every 6 weeks for at least 1 year in addition to their workplace practice preceptor.

Overseas applicants

A similar process is followed by all the boards in the way they initially screen overseas applicants. The processes includes a test for English language proficiency, approving the qualification and an individual assessment against the board's competencies. After gaining registration, the overseas applicant is either placed on the standard return to work or new graduate pathway or has an individualised supervision plan prescribed. All boards emphasise applicants are considered individually and registration and certification is at their discretion.

[12] The Nursing Council completed an extensive consultation process in 2014–2016 before altering the scope of practice of nurse practitioners (as opposed to registered or enrolled nurses), which included a proposal of mandating 1 year of supervision for newly registered nurse practitioners. Despite the consultation with the profession showing "a high level of support for the proposed new competencies and a requirement that new nurse practitioners practise under supervision for one year" (Nursing Council of New Zealand, 2016), this has not been ratified into the process that came into effect on April 2017. Rationale for this final decision could not be located on the Nursing Council website.

Table 4: Aotearoa New Zealand regulatory practices (as at March 2017).

Regulatory authority	New graduate conditions	Returning to practice conditions	Overseas applicant conditions
Physiotherapy Board of New Zealand	• No conditions.	• Required after 3+ years without APC, either supervision period or exam and then supervision for at least 6 months. • Highly prescribed supervision or oversight for a period, usually 3 or 6 months (though the Board reserves the right to alter the period of supervision). There are activities that must take place at certain points during a period of supervision. These are: • Clinical reasoning/case study discussion between the applicant and the supervisor. These discussions must occur weekly for the first month of supervision. The frequency may be decreased from the second month onwards at the Board's discretion. • A peer review after the first month and the third month of supervision. In cases where the specified period of supervision is 6 months, there must be a third peer review carried out after the 6th month. • Attendance at professional development/in-service meetings. The returner must attend these meetings at least monthly. • The applicant and the supervisor must submit reports to the Board at certain times during the supervision period. These reports will be assessed and feedback will be provided to	• There is no accreditation of overseas courses. Each application is individually assessed. • Use recertification (competence) programme to ensure competence. • Require cultural competence reflective statement. • Have recently (May 2016) produced combined "practice thresholds" with the Australian Board to measure competence. These are based on the CanMEDS framework, developed by the Royal College of Physicians and Surgeons of Canada (Royal College).[15]

[15] https://www.physioboard.org.nz/sites/default/files/PhysiotherapyPractice%20Thresholds3.5.16.pdf

Regulatory authority	New graduate conditions	Returning to practice conditions	Overseas applicant conditions
		the applicant and supervisor.[13] • Recent review of process showed that, from 2005 until 2015, 143 physiotherapists had applied for an APC after a break of 3 or more years. 70% of these were successful in returning to practice. The majority (62%) were out of practice for 3–5 years. This figure has remained consistent over the programme's 10 years duration.[14]	
New Zealand Psychologists Board	• Eligibility for a clinical psychologist, counselling psychologist and educational psychologist scope of practice requires a Board-approved practicum or internship involving 1,500 hours of supervised practice. • Supervision to registration scheme, is currently only available to employees of the Department of Corrections and the New Zealand Defence Force. Trainee psychologists must hold a current practising certificate, which will include supervision conditions. • Supervision should be a minimum of 2 hours per month for psychologists who work full-time and 1 hour per month for part-time psychologists (6/10ths or less). The frequency of supervision may need to be increased in some situations, including (but not limited to) where the supervisee is a trainee or student psychologist.16	• Required after 3+ years without APC. • Each application will be assessed on its merits to determine whether or not an APC should be issued, whether or not formal retraining will be required, whether or not any conditions should be imposed and the duration of any prescribed monitoring regime. • Decision will be no special requirements, a transitional period of supervised practice is required or formal retraining is required. • A proposed supervision plan would include a self-reflective review (SRR) identifying competencies in need of rehabilitation, a set of clear learning objectives based on the SRR, a set of learning plans to achieve the learning objectives identified and a detailed supervision plan (including details of the proposed	• Applications from overseas-qualified practitioners are assessed on an individual basis for fitness for registration, equivalence of the applicant's qualifications to New Zealand qualifications and competence to practise. • If applicants meet requirements, they follow same processes as interns, trainees or general scope of practice psychologists.

[13] http://www.physioboard.org.nz/outcomes-supervision
[14] http://www.physioboard.org.nz/findings-return-practice-programme-review
[16] http://www.psychologistsboard.org.nz/cms_show_download.php?id=220

Regulatory authority	New graduate conditions	Returning to practice conditions	Overseas applicant conditions
		supervisor and frequency of supervision). • If the supervision plan is acceptable to the Registrar, an APC with a condition requiring Board-approved supervision (including regular reports to the Board from the supervisor) would be issued. The condition would be reviewed after a prescribed period (commonly 1 year) of monitoring, and would be lifted if there were no concerns arising.17	
Dietitians Board	• All entry-level practitioners to have practice supervision for a minimum of 1 year and this is entered as a condition on the practitioner's APC. • The Board requires at least fortnightly supervision for the first 6 months of the supervisory period regardless of full-time or part-time work. Following that, 1 hour of formal supervision per month may suffice, especially for those with previous dietetic work experience. • Once the supervision period is completed, the supervisor must complete the supervisor sign-off.[18]	• Returning after 3–9 years absence: identify a mentor and develop and submit a professional development learning plan focused on transition back to practise, which must be signed by the mentor. • Any dietitian who wishes to prescribe must sit and pass the Prescriber Training Course offered annually by the Board before their APC can be endorsed. • All assessments will be made on a case-by-case basis but should expect to undertake 15 months' supervision – fortnightly for the first 3 months and then on a monthly basis – and to be called for audit after 1 year. • 9+ years should expect to be required to sit and pass the Board Examination before being permitted to practise dietetics, then the	• Qualifications individually assessed. • Written and oral examination to be passed within the same 3-year period. • 1 year practice supervision.[20]

[17] http://www.psychologistsboard.org.nz/cms_show_download.php?id=287
[18] http://www.dietitiansboard.org.nz/Practitioners/Supervision
[20] http://www.dietitiansboard.org.nz/Registration/Overseas-Trained

Regulatory authority	New graduate conditions	Returning to practice conditions	Overseas applicant conditions
		supervision/audit requirements as above.[19]	
Nursing Council of New Zealand	• No supervision conditions. • The Nursing Council is involved in approving and monitoring the Nurse Entry to Practice (NETP) programmes under an agreement with Health Workforce New Zealand. These year-long programmes focus on supporting new graduates through their first year in the workforce as they make the transition from student nurse to competent registered nurse. NETP programmes are provided by District Health Boards, and there are limited spaces available. NETP programmes are not mandatory for new graduates. However, they do provide a supportive process to enable the transition to the competent registered nurse.21	• 5+ years without APC. • No supervision conditions. • Competence assessment programmes used. These programmes are generally 6–8 weeks long and provided by polytechnics or large employers (e.g. Bupa) and include a theoretical and a clinical component.22	• No supervision conditions. • Must pass an assessment of the Nursing Council Competencies for Registration. • Successful completion of a Nursing Council-approved competence assessment programme.
Midwifery Council of New Zealand	• All new graduate midwives must complete the New Zealand Midwifery First Year of Practice Programme (MFYP). This programme is administered by the New Zealand College of Midwives under contract to the government. • MFYP involves set workshops and a formal mentoring arrangement. • In addition to the above, a non-compulsory new Midwifery Practice Skills (MPS) support programme has recently been funded. Graduate midwives may choose midwifery practice	• 3–5 years without APC – conditions on scope limiting practice, must participate in highly structured return to practice programme. • 5–10 years without APC involves further conditions on scope involving additional education • Return to practice (RTP) programmes are required to have a period of supervised practice across the midwifery scope. • An interim practising certificate is issued. • A plan must be provided to the Council including the	• A number of conditions on scope of practice that reflect competencies required of midwives in New Zealand that do not have a parallel in other jurisdictions. • Must practise either as an employed midwife or within an established group practice, which means formal professional practice arrangements with structured back-up and regular practice meetings. No midwives in the practice may be under Council processes. • Will also be required to have a mentor who will be

[19] http://www.dietitiansboard.org.nz/Practitioners/Return-to-Practise
[21] http://www.nursingcouncil.org.nz/Education/Registered-nurse
[22] http://www.nursingcouncil.org.nz/Nurses/Continuing-competence/Competence-assessment

Regulatory authority	New graduate conditions	Returning to practice conditions	Overseas applicant conditions
	skills support over their first year of practice for a variety of reasons, enabling further development of clinical skills and gaining more confidence in certain clinical situations. Each graduate on the MFYP has identified specific learning needs, which are detailed in the Professional Development Plan (PDP). The aim of the MPS is to provide all graduate midwives with the opportunity for clinical support from either the named MFYP mentor and/or up to two other midwifery colleagues who are on the current MFYP mentoring database.23 • New graduate midwives, both New Zealand-educated and internationally qualified, are expected to undertake a Midwifery Standards Review (MSR) at the end of their first year of practice. The Council contracts the New Zealand College of Midwives to undertake MSR.24	named preceptor for the period of time. • The preceptor midwife must have completed a Council-approved preceptorship course. • Mentors are expected to meet with the midwife every 6 weeks. Mentors are an agent of the Council and will be appointed for this purpose. The mentor will be required to provide reports at the end of year one and the end of the RTP programme and at any other time should they have concerns regarding the midwife's practice. The midwife is required to self-fund the cost of having a mentor. The mentor fees are gazetted at $80.00 per hour. In the gazette, this is referred to as supervision.25 • All midwives will have their progress through the RTP programme monitored. Midwives will be advised if their progression through the plan is not at the required level, i.e. when they fall behind with any requirements. • Once the requirements have been successfully completed in any of the categories, the midwife will need to provide evidence to the Council. On receipt of successful completion of the above requirements, the	formally appointed to the role by the Council. • A report will be sought from the mentor at the end of each year until the Overseas Competence Programme is completed, giving feedback on integration into the New Zealand maternity system.27

[23] https://www.midwife.org.nz/quality-practice/midwifery-first-year-of-practice/
[24] https://www.midwiferycouncil.health.nz/midwives/maintaining-competence/recertification-requirements
[25] https://gazette.govt.nz/notice/id/2014-gs1082
[27] https://www.midwiferycouncil.health.nz/midwives/becoming-registered-practise/internationally-qualified-midwives-application-guidelines

Regulatory authority	New graduate conditions	Returning to practice conditions	Overseas applicant conditions
		midwife is issued with a full APC.26	
Education Council of New Zealand	• Provisionally certificated teachers are teachers who are yet to meet the Practising Teacher Criteria for the first time. During their induction into the teaching profession, they will be required to document the process of induction and mentoring they have undertaken over at least 2 years and maintain a folio of evidence that will enable their mentor teacher and professional leader to confirm to the Education Council that the provisionally certificated teacher has met all of the criteria. • Moving from provisional to full certification: be employed in a teaching position of at least 0.5 Full Time Teacher Equivalent (FTTE) in New Zealand; teach in a continuous position (teaching of less than 6 weeks is not considered); be employed as a teacher – not a teacher aide or a volunteer worker – in the general education system; participate in an induction programme being mentored and supported by a fully certificated mentor teacher (for at least 2 years held a current practising certificate); have completed satisfactory recent teaching experience.[28]	• 6+ years without current practising certificate. • Must complete a teacher education refresh (TER) programme – fully online with individual support [as appropriate]. • Consists of four modules that can be completed in flexible timeframes, as negotiated with each participant, and within a 6-month period. • Includes a 20-day practicum, which will be individually negotiated and tailored to suit each teacher's circumstances. • Will be assessed through an evidence based e-portfolio against Graduating Teacher Standards. This e-portfolio can also be used for evidence against the Practising Teacher Criteria. Evidence can be generated from completing weekly online tasks and/or from classroom practice.[29]	• Overseas qualifications assessed by NZQA. • At Education Council's discretion • The Council requires some teachers to complete a TER programme.

[26] https://www.midwiferycouncil.health.nz/sites/default/files/for-midwives/return-to-practice/Return%20to%20practice%20policy%20November%202015.pdf
[28] https://educationcouncil.org.nz/registration-policy#part-c-pathway-to-being-issued-with-a-full-practising-certificate
[29] https://education.waikato.ac.nz/qualifications/choose-a-subject/teacher-education-the-faculty/teacher-education-refresh-programme/

OTBNZ operational data and supervision as a regulatory tool

The broad research question “Is the use of supervision as a standard condition achieving the purpose of ensuring safe occupational therapy practice?” was used to guide the examination of OTBNZ use of supervision as a standard condition on scope of practice. A mixed method approach was utilised with both quantitative and qualitative data collection. The methods of data collection were a statistical analysis of historical data held by OTBNZ, a voluntary anonymous online questionnaire and an analysis of the free-text comments provided by the questionnaire respondents. All data for analysis was de-identified and held on a secure, password-protected server. Statistical analysis was performed where appropriate using GraphPad QuickCals online.[30] Other numerical data was mined from the administrative records that OTBNZ holds.

Historical data

Historical data related to practitioners with conditions on their scope of practice was extracted on 9 February 2018. This data was then categorised into three groups according to the compliance and length of time the condition had been on the scope of practice. The length of time that practitioners held their condition was calculated from the time since the imposition of the condition.

Compliant was designated as the imposed time (12 months for new graduates and 6 months for overseas qualified and returning practitioners) plus 1 month. Overdue was classified as the imposed time plus up to 6 months, and the third category was for those who were overdue by more than 6 months.

These groups were further divided into those that held a practising certificate and those that did not. Unpaired t-tests were used to investigate any differences between groups.

[30] www.graphpad.com/quickcalcs/

Questionnaire

An online questionnaire of practitioners who have had recent experience with delivering and receiving supervision for a condition of practice was conducted to investigate their experience and views of the current process. Practitioners were selected by identifying occupational therapists who had successfully applied for their condition to be removed in the last 18 months and identifying their supervisor. A total of 263 supervisees and supervisors met this criteria and were invited to voluntarily participate in an anonymous online survey via an email sent by OTBNZ. The survey was hosted by SurveyMonkey and accessed via the link provided. A reminder email was sent after 1 week, and the survey closed after 2 weeks. A prize offer of two $100 book vouchers was offered to both groups to encourage participation. The questionnaire contained 17 questions for supervisees and 20 for supervisors (Appendix 1) with a combination of multiple choice (single or multiple answer), Likert scales and free-text comments to provide answers. The questionnaire was adapted for supervisors and supervisees but essentially replicated the same questions for the two roles. Supervisors who had supervised multiple practitioners were asked to respond with respect to the most recent practitioner they had supervised.

Results

On the day of data extraction, 17% (631) of all registered practitioners held a condition on their scope of practice – the largest proportion being practitioners with a new graduate condition (Table 5).

Table 5: Registered practitioners with conditions on their practice on 9 Feb 2018.

Condition	Number of practitioners	Percentage of total registered practitioners
New graduate	432	12%
Overseas qualified	121	3%
Return to practice	78	2%
Personalised	4	0.1%
Total	631	17%

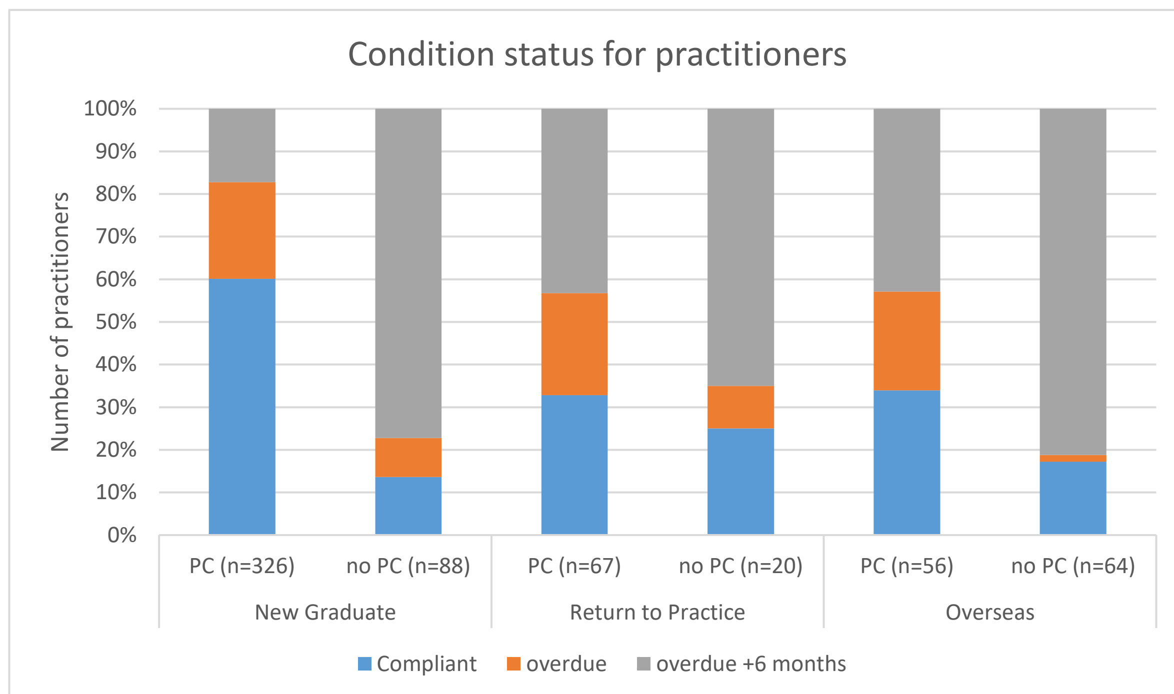
A comparison of condition applications and removal was done for the last 3 years of data held by OTBNZ. The number of applications for removal was substantially lower for all years, suggesting that, for many practitioners, the 6-month and 12-month timeframes for supervision were not adhered to. Table 6: Standard conditions imposed and removed – includes new graduate, return to practice and overseas conditions.

Table 7: Standard conditions imposed and removed – includes new graduate, return to practice and overseas conditions.

Year	Standard conditions imposed	Applications for removal
2015	249	146
2016	218	175
2017	246	127

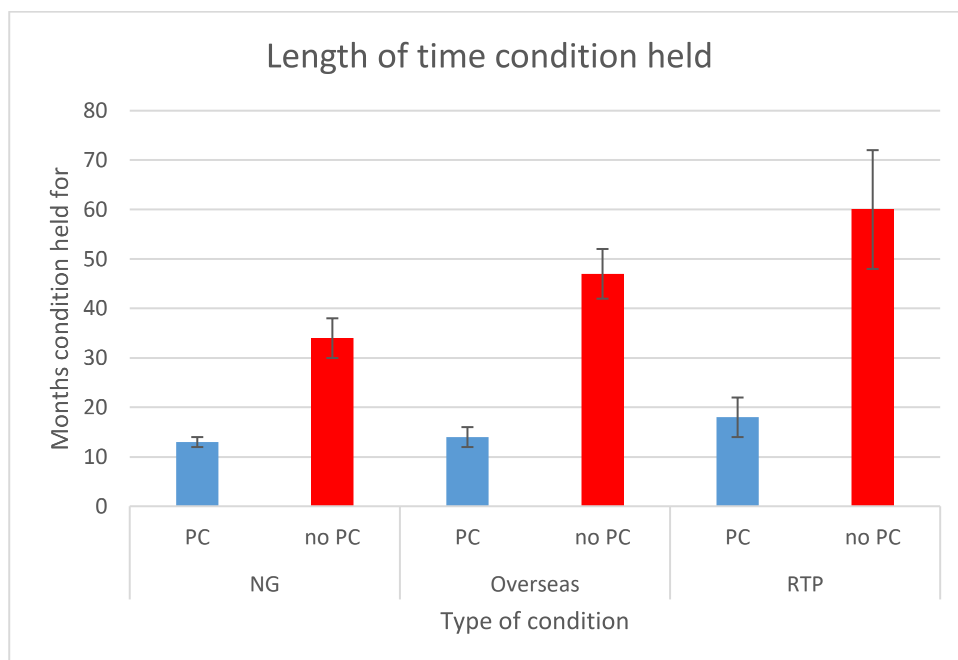
A significant proportion of practitioners had conditions on their practice that were overdue for removal (Figure 1). All groups had at least 40% of practitioners who had conditions overdue for removal by more than 1 month, of which at least 17% were overdue by more than 6 months.

Figure 1: Status of conditions held by practitioners with different types on conditions. PC indicates holding a practising certificate. Overdue = more than 1 month past due date, overdue + 6 months = more than 6 months past due date.



New graduate practitioners who held a practising certificate were the most likely to have their condition removed in a timely manner. The average length of time this condition is held by this group is 13 ± 1 month (Figure 2). The average time for those with overseas and return to practice conditions is 14 and 18 months respectively, considerably longer than the 6 months expected. Practitioners who did not hold a practising certificate have held conditions for significantly longer than those who had a current practising certificate for all types of condition ($P<0.0001$, unpaired t-test for each group). Returning practitioners had the highest level of overdue conditions. As the occupational therapy workforce is considerably impacted by therapists leaving the profession, this finding is worth particular note for OTBNZ.

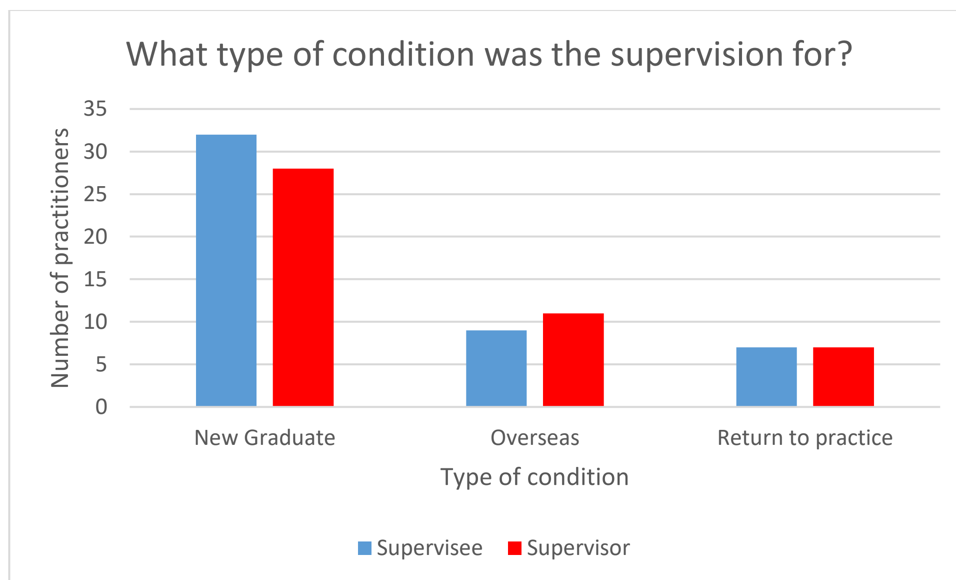
Figure 2: Length of time conditions on scope of practice held for in each group. Bars represent mean ± 1 SEM.



Questionnaire results

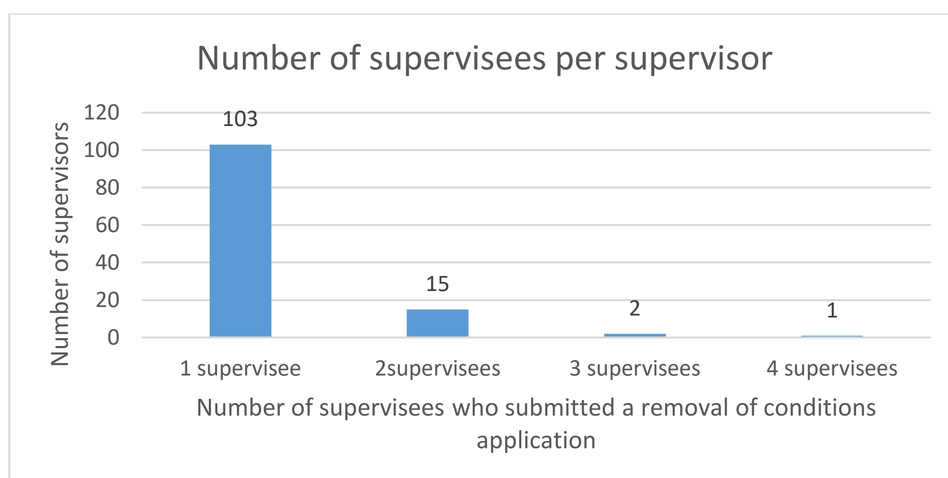
Of the 263 practitioners invited to complete the online questionnaire, 49 (34%) of supervisees and 46 (38%) of supervisors participated. Due to the predominance of the new graduate condition in the three groups of practitioners who are required to practise with a standard condition, most of the respondents were supervisors or supervisees with a new graduate condition on scope of practice (Figure 3). Due to the small number of practitioners in the overseas and return to practice condition, comparisons were made only between the supervisor and supervisee groups.

Figure 3: Breakdown of condition types for supervisees and supervisors who responded to the survey.



The disparity in the number of supervisees (n=49) to supervisors (n= 46) in the sample selected for the survey indicated that some supervisors were supervising multiple practitioners over the period investigated (Figure 4). Most supervisors supported the removing of condition of a single supervisee over the 18-month period. Only one supervisor signed off four supervisees during the period.

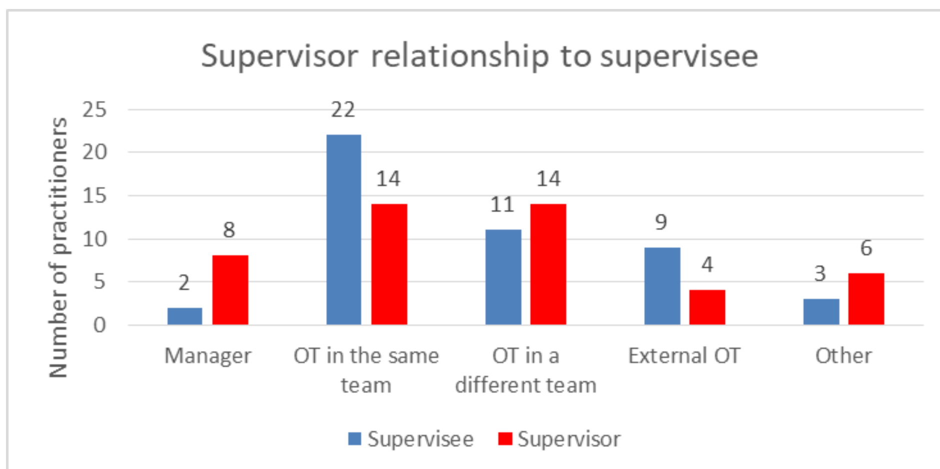
Figure 4: Comparison of supervisors supervising multiple practitioners.



The arrangement and conduction of supervision was also explored in the survey. Approximately half (51%) of the supervisees were assigned their supervisor by their employer, with the other half choosing the supervisor themselves or having some input into the choice. Only two of supervisees had a direct manager as their supervisor, although eight supervisors reported that they were also the manager of their supervisee (Figure 5). Roughly one-third of supervisors (31%) reported supervision outcomes to external parties other than OTBNZ, but the extent of what was contained in this reporting is unknown.

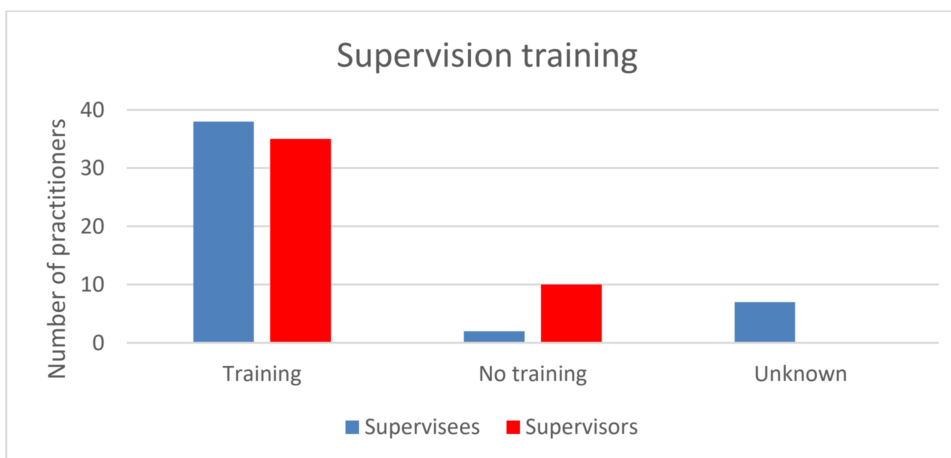
Most supervision was provided by an occupational therapist from within the same organisation. The most common organisation was a District Health Board (DHB), with 63% of the supervisees and 70% of the supervisors working for DHBs. This is significantly higher than the overall occupational therapy workforce, where only 49% of occupational therapists have indicated they are employed by DHBs (OTBNZ, 2018). The over-representation of DHB employees suggests that a high proportion of new graduates find their first employment roles at a DHB. Accordingly, the mandatory weekly supervision required to meet the new graduate condition is being met predominantly by the public health system. There were nine supervisees (18%) who reported having an external supervisor, two of which self-funded this supervision themselves. All of these nine supervisees worked in mental health.

Figure 5: Supervisory relationship.



Most (91%) of the supervisees reported they had a formal, written supervision agreements, and just over three-quarters of supervisors (78%) had attended some form of supervision training (Figure 6).

Figure 6: Supervision training – supervisors were asked about their own training, and supervisees were asked about the training of their supervisor.

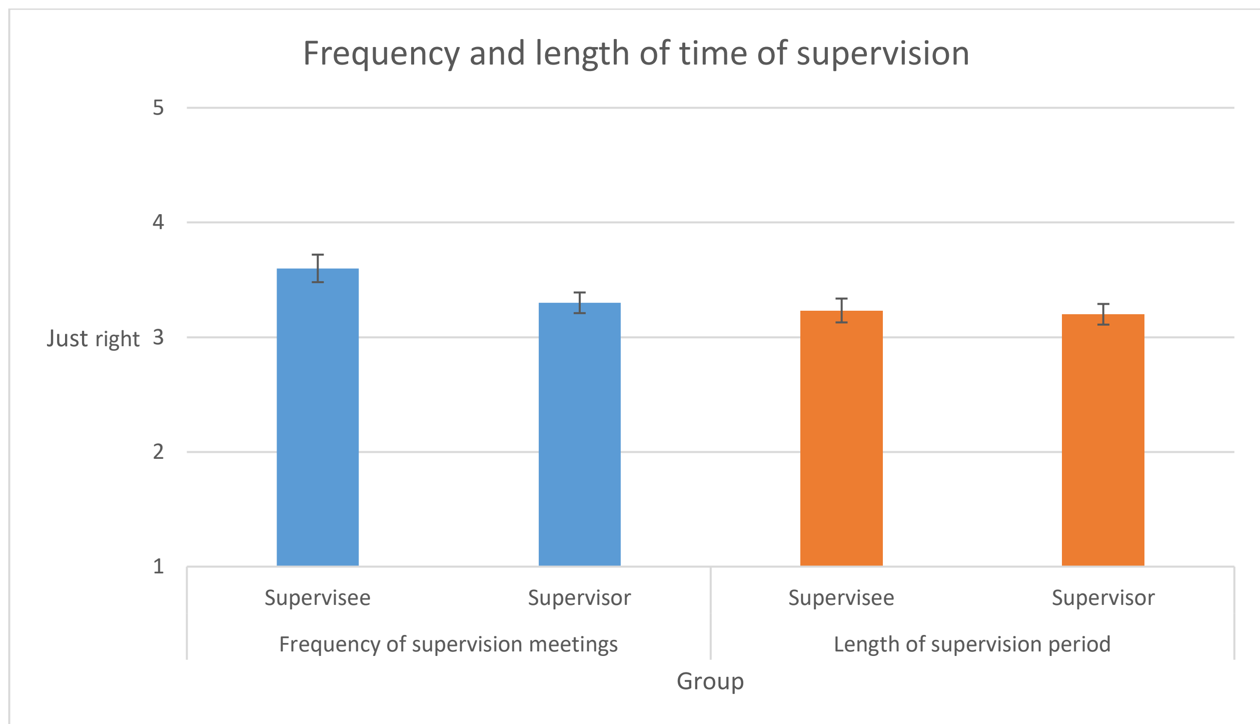


Almost all supervisees and supervisors (96%) reported that meeting kanohi ki te kanohi/face to face was the predominant method of how supervision was delivered. A small number (three supervisors and one supervisee) reported they met via Skype or via phone.

Participants were asked to rate (not enough, just right, too much) the frequency of supervision meetings (weekly or fortnightly) and the length this was required (6 or 12 months). This data was grouped and analysed using t-tests to determine any differences. No significant difference was found between the responses of supervisees or supervisors for either the frequency of meetings ($p=0.39$) or the length of time the condition was imposed ($p=0.84$). Data from both supervisors and supervisees was therefore combined for further analysis.

Both supervisees and supervisors rated the frequency of supervision significantly more than 'just right' (p=0.001), indicating that, overall, the frequency of meetings was felt to be too often (Figure 6). The length of time supervision is imposed was also rated as significantly longer than 'just right' (p= 0.0019), again indicating that the length of the supervision period was felt to be too long by both the supervisee and supervisor.

Figure 7: Both groups ranked frequency of supervision meetings and the length of time supervision was required on a 5-point Likert scale. 1= not often enough (for frequency) or not long enough (period), 3= just right, 5= too often (for frequency) or too long (for period). Error bars represent 1 SEM



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Several respondents made free-text comments in response to the questions about the timeframes of supervision. These responses provided insight into the factors that can influence whether the mandatory length of time or frequency of supervision was deemed necessary.

Factors mentioned were:

- maturity of practitioner
- previous life experience
- years of previous occupational therapy experience
- area of practice
- time to reflect on discussion from previous supervision
- other supports for the practitioner
- part-time or full-time position

Content of supervision

Both groups were asked questions relating to the content of the supervision provided. Almost all had discussed workload management, reflective practice and the OTBNZ mandatory ePortfolio system (Table 8).

Table 8: Content of supervision.

Supervisee	n=45	Supervisor	n=46
Workload management	89%	Workload management	96%
Reflective practice	84%	Reflective practice	93%
ePortfolio	84%	ePortfolio	93%
Case studies	82%	Ethics and boundaries	91%

When asked to identify what they felt was the important content to cover in supervision, there was a mismatch between supervisors' and supervisees' opinions (Table 9). Supervisors highly rated ethics and boundaries as part of the content of supervision, but this was not identified at all by the supervisees. Supervisees identified cultural competence, the health system and evolving areas of practice as high-level topics whereas the supervisors did not. The lack of identification of cultural competence as an important aspect of supervision is notably absent in the supervisors' responses and is a flag that this may be an area that requires targeted attention.

Table 9: Perceived importance of content of supervision.

Supervisee	n=45	Supervisor	n=46
Evolving areas of practice	78%	Clinical reasoning	96%
New Zealand health system	60%	Practice skills	89%
Cultural competence	53%	Professional boundaries	73%
		Professional ethics	67%

Along with the specific content of supervision, the questionnaire also asked what other forms of professional development had been accessed by the practitioners during the period of mandatory supervision (Table 10).

Table 10: Additional professional development.

Supervisee	n=44	Supervisor	n=45
Seminar or workshop attendance	64%	Peer support groups	67%
E-learning (e.g. online seminars)	48%	Cultural training	67%
Cultural training	48%	Seminar or workshop attendance	62%
Literature review/case studies	43%	E-learning (e.g. online seminars)	60%

Both groups indicated they had utilised cultural training, seminar or workshop attendance and e-learning. When asked what methods of professional development respondents preferred, e-learning was indicated as the preferred option for both groups (63% of supervisees and 75% of supervisors). Supervisees were also asked the question: "How helpful was supervision in supporting your transition to working as an occupational therapist in New Zealand?" Supervision was rated an average of 4.5 ± 0.1 (mean ± SEM) on a 5-point Likert scale, indicating supervisees highly valued the experience of supervision.

Discussion

The original question the research sought to answer was to examine whether supervision as a standard condition was achieving the purpose of ensuring safe occupational therapy practice in Aotearoa New Zealand. The comparative analysis of other regulatory practices and the examination of the outcomes of OTBNZ use of mandatory supervision illustrates the complexity of regulating a practice such as supervision. The following discussion is intended to assist with informed right-touch regulatory practice as well as assist in decision making about operational processes related to the administration of supervision as a standard condition on scopes of practice.

Using supervision as a mandatory condition

OTBNZ currently has standard conditions for three groups of practitioners when they seek to commence practising – overseas qualified, returning to practice and new graduates. In the research literature, there is little evidence to indicate that these groups are a high risk to the public for unsafe practice. Despite this, there is an international regulatory norm that these three groups require mandatory regulation intervention to be safe and competent practitioners. The role and effectiveness of supervision in supporting these practitioners to be safe and competent has similarly been accepted as a regulatory norm to mitigate this risk. Alternatively, supervision as utilised in this context could also be viewed as achieving its purpose in providing safe occupational therapy by contributing to the low levels of complaints against occupational therapists.

Mandatory supervision was used by most regulators of occupational therapy around the world (see Table 3) for the same groups of practitioners as OTBNZ. Many of the regulators of other professions in Aotearoa New Zealand also utilised some form of mandated supervision, with sign-off by a supervisor before the requirement for supervision is lifted. What was less consistent was the level of direction of how this supervision was to be carried out. In this respect, OTBNZ was one of the few regulators who have very detailed requirements, directing the frequency of supervision, reporting requirements and the type of supervision required. Despite this level of guidance, however, there is a significant lack of successful completion of removing the standard conditions of scope of practice within the timeframes given.

Integrity of the public register of occupational therapists

Data held by OTBNZ indicated that a large number of practitioners continue to hold conditions on their practice past the eligible date for lifting. There is also a notable number of practitioners who never remove their condition and do not reapply for a practising certificate. The reasons for this are not clear. It does mean that practitioners with overdue conditions are either continuing to have more frequent supervision than may be required (at the cost of time and resources to both the supervisor and supervisee), are not complying with the legal requirement of their condition for supervision or are leaving the profession.

The continuation of a condition on practice beyond when is required may have several implications on the practitioner, the employer and OTBNZ. The presence of a condition on scope of practice alerts the public to the fact the practitioner is not able to practise in the standard manner and may influence the way the practitioner is perceived. Practitioners whose condition is not lifted are also potentially misrepresented on the register when they may in fact be competent to practise without the condition.

The trend of practitioners who do not have a current practising certificate still having a condition on their scope of practice also has operational and return-to-practice implications. Having a condition still on their scope of practice is a potential barrier for practitioners wishing to return to practice, representing a risk of practitioners instead choosing to leave the profession. It also means higher levels of administrative scrutiny need to occur when they choose to return or to follow up why they have not applied to remove their condition. As supervision reports are not submitted by the supervisor until a practitioner applies to have their condition removed, it cannot be ascertained what has happened in the situation where the applicant is delayed.

Operational and legislative implications for OTBNZ

Alongside maintaining the integrity of the register is a separate issue related to the use of terminology in relation to scopes of practice. Differing terminologies that refer to the same practices was highlighted in the comparative analysis of other regulators and is also currently a topical subject in the Aotearoa New Zealand legislative environment. Conditions on scopes of practice are currently one of the proposed amendments to the Health Practitioners Competence Assurance Amendment Bill that is before Parliament. The proposed changes are likely to increase the level of notification expected by regulatory authorities to employers and the public when conditions on practice

are imposed. This means that OTBNZ will need to make individual notifications about each practitioner who has a condition on their scope of practice.

As there are a significant number of practitioners with conditions on their scopes of practice on the OTBNZ register – 14% (398) at 1 April 2018 – any increase in notifications will need a corresponding increase in administrative processing. The current use of 'standard condition on scope of practice' presents a risk of increasing costs to OTBNZ in operationalising new requirements of an amended HPCA Act. Other regulators in Aotearoa New Zealand and international occupational therapy regulators use alternative terms to designate standard conditions, such as 'interim' (New Zealand Psychologists Board) or 'provisional' (Teachers Council of NZ), reserving the use of 'condition on scope of practice' for conduct, competence or health reasons. The differing use of the term is potentially confusing to the public, including employers of occupational therapists. Having aligned terminology and language is important for clear communication. Continuing to use the term 'condition on practice' may raise unwarranted concern with employers and members of the public. It also creates the possibility that, when personalised conditions that do relate to conduct, competence or health are applied to a practitioner's scope of practice, these are confused with a standard condition and not given enough gravity by employers or the public.

Operational implications for practitioners

The delay in removing conditions for many practitioners suggests that the way mandatory supervision as a standard condition is being delivered and operationalised may need adjusting. The analysis from the online questionnaire showed that both supervisees and supervisors who had completed the process successfully felt ready for the removal of the condition on or before the time stipulated by OTBNZ. It also showed supervisees highly valuing the supervision they received. Conversely, the historical data showed low levels of compliance of practitioners to complete the process to remove the conditions, particularly those with overseas-qualified and return-to-practice conditions on their scope of practice.

These two findings suggest that mandatory supervision is not universally meeting the diversity of need of the three groups of practitioners it is applied to. There is currently a degree of flexibility in how supervision is delivered (face to face, remote and peer supervision are acceptable) as well as an option to apply for conditions to be removed before the mandated time period. There has been little uptake of supervisees applying for early removal of their condition (personal communication Registration Team, OTBNZ, 2019). What is not flexible is the frequency of weekly or fortnightly supervision, the provision of formal documentation of this in the form of a signed supervision log and a supervisor report that supports the application. It is possible that these administrative and resource-heavy aspects of using supervision as a standard condition on scope of practice are forming a barrier for some practitioners in applying for removal of their condition.

Practice implications

OTBNZ currently does not require supervisors to have any training in supervision before they can supervise another practitioner. This was also the standard practice of most of the international occupational therapy regulators reviewed. While results from the survey indicated that the majority of supervisors had undertaken some supervision training, 70% of these supervisors were based at DHBs. As half of the practising occupational therapy workforce do not work for DHBs, a generalisation of this level of training to the rest of the workforce's supervisors cannot be made.

Another finding of concern was that supervisors did not rank providing supervision about cultural competence highly whereas supervisees did. The mismatch of expectations related to cultural competence is despite bicultural practice being a discrete and prominent competence expectation[31] for all practising occupational therapists. The lack of translation of cultural competence as an occupational therapist to supporting cultural competence as a supervisor suggests that additional support and education in providing this may be required.

A lack of training of supervisors or the need for further training was a consistent theme and/or recommendation in the literature discussing both harmful and effective supervision (Beddoe, 2017; Davys, 2017; Davys, May, Burns & O'Connor, 2017; Ellis et al. 2014; Landon & Shultz, 2018; Reiser & Milne, 2016). Providing a Board-related supervision framework and training for the provision of mandatory supervision was also one recommendation made by Simmons Carlsson and Herkt (2012) in their review of the use of supervision by OTBNZ. Developing a formal framework for the provision of competent supervision was also a consistent recommendation in the literature (see recent special edition of *The Clinical Supervisor* 36(1), 2017;

[31] (Competency 2: Practising appropriately for bicultural Aotearoa New Zealand, Competencies for Registration and Continuing Practice, OTBNZ, 2015)

Davys, May, Burns and O'Connor, 2017) as a way to mitigate against harmful, ineffectual and institutionalised supervision practices. Having a consistent understanding of the skills and knowledge necessary to provide supervision which supports OTBNZ expectations of competent and safe practitioners continues to be missing in the way mandated supervision is operationalised.

Conclusion

From this analysis, it has been determined that there is not enough evidence to support any change in the standard mandatory timeframes of 6 or 12 months and weekly and fortnightly supervision requirements for practitioners with standard conditions on their scope of practice. However, there are changes that OTBNZ could implement that may assist with the operational issues and administrative barriers that may be making these conditions difficult to remove. The OTBNZ will also investigate the method of application used to mandate supervision to ensure that the implications are appropriately transparent and understood by practitioners, employers and the public. Additional exploration into the use of mandated supervision and the outcomes for the practitioners involved is also indicated and future directions for additional research could include:

- A qualitative examination of the experience of supervision by supervisees who have received mandated supervision.
- An investigation into the experience of practitioners returning to practice and how the return to practice process supports this.
- A review of the challenges faced by overseas-qualified practitioners when beginning practice in New Zealand and reasons for conditions not being removed.
- An analysis of practitioners' non-removal of return to practice, overseas qualified and new graduate conditions and lapsing of practising certificates (loss to the profession).

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Appendix 1: Online survey questions

Supervisee	Supervisor
• What kind of supervision condition did you have on your practice?	• What condition on practice did your supervisee have?
• What was your relationship to your supervisor?	• What was your relationship to your supervisee?
• What type of organisation were you employed by?	• What type of organisation was your supervisee employed by?
• What area of occupational therapy do you work in?	• What area of occupational therapy did your supervisee work in?
• How did you meet with your supervisor?	• How did you meet with your supervisee?
• Was the frequency of supervisory meetings: not enough – just right – too often (5-point Likert scale)	• Was the frequency of supervisory meetings: not enough – just right – too often (5-point Likert scale)
• Was the length of time the supervision imposed: not enough – just right – too often (5-point Likert scale)	• Was the length of time the supervision imposed: not enough – just right – too often (5-point Likert scale)
• What areas of practice did you discuss in your supervision?	• What areas of practice did you discuss with your supervisee?
• Did you use any other supports during your period of supervision?	• Did your supervisee use other methods of learning or support during the supervision period?
• What other methods of support would you find useful in supporting you during your supervision period?	• What other methods of learning are useful in supporting your supervisee?
• What areas of practice would you find helpful to learn about?	• What areas of practice do you think supervisees need to learn about?
• How many years of experience as an OT did you have when beginning supervision?	• How many years of experience as an OT do you have?
• Did your supervisor have any training in supervision?	• Do you have any training in supervision?
• Who funded your supervision?	• Were OTBNZ expectations for supervision clear?
• Did you have a choice of supervisor?	• Do you keep supervision records?
• Did you have a supervision agreement with your supervisor?	• Do you know what is expected in the supervision report to OTBNZ for condition removal?
• How helpful was supervision in supporting your transition to working as an occupational therapist in New Zealand?	• Are your supervision outcomes reported externally?
	• How many practitioners have you supervised?
	• What resources do you use in your supervision?
	• What resources would you find useful to support you in your supervision?