

Enablers and barriers to interprofessional work-integrated learning placements: A qualitative study of rural and regional allied health supervisors' perceptions

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Work-integrated learning (WIL) is central to the delivery of high quality student learning that provides students with the knowledge, skills, attitudes and professional networks for successful careers. In rural and regional Australia WIL placements can be particularly challenging to source due to limited clinical supervision capacity. This article reports regional Allied Health clinical supervisors' perceptions of enablers and barriers to engaging with interprofessional student WIL. A phenomenology of practice framework was used to interpret the data, highlighting three key themes: introducing an interprofessional lens early; tapping into unique possibilities; and setting up for success, balancing challenges with opportunities. The study identified key elements that may contribute to successful Allied Health interprofessional WIL placements in rural and regional settings, including incorporating early student placement opportunities, using shared interprofessional supervision to foster the development of junior clinicians' supervisory skills, and ensuring clarity around the purpose and processes of each interprofessional placement.

Keywords: Allied health, interprofessional supervision, interprofessional WIL, rural WIL

Work-integrated learning (WIL) is a central part of the education of health professional students, through supporting essential skill acquisition or refinement (McBride et al., 2015), providing opportunities to develop professional reasoning, psychomotor abilities, and effective communication skills (Towns & Ashby, 2014), as well as cementing links between theory and practice (Nagarajan & McAllister, 2015). Importantly, WIL enables authentic assessment of skills students have developed in academic contexts, within a workplace environment. Despite the acknowledged centrality of WIL experiences in developing Allied Health students' professional capabilities, provision of quality experiences is becoming increasingly difficult in contemporary Australian healthcare and education contexts (McBride et al., 2015). Multiple mentoring, or shared supervision of students, has been identified as one possible solution to this challenge (Cleak & Smith, 2012; Copley & Nelson, 2012; Graves & Hanson, 2014). However, this model is primarily uni-professional and, as such, requires sufficient numbers of appropriately experienced supervisory staff from a single profession. Implementation of this approach in rural and regional settings is limited by staffing constraints.

There is a well-documented shortage of Allied Health practitioners in rural, remote and regional areas within Australia (Adams et al., 2016; Australian Institute of Health and Welfare, 2013). Evidence suggests that students who experience WIL in a rural and regional area are more open to practising in those environments after graduation (Brown et al., 2017; Crowe & Mackenzie, 2002; Fatima et al., 2018; McNair et al., 2005; Playford et al., 2006). Clinical supervisors in rural and regional areas therefore play a crucial role, not only in student education but also in the future recruitment and retention of graduates in these settings. Meeting the increasing demand for Allied Health WIL, or clinical placement, has

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historically been typified by a lack of coordination across Allied Health disciplines (McBride et al., 2015), however, more recent research identifies collaboration between university and health sectors as a key enabler for the sustainability of WIL provision, particularly in the creation of interprofessional opportunities (McBride et al., 2018).

Interprofessional education is considered critical in contemporary healthcare to prepare Allied Health students for enhanced patient outcomes through collaborative healthcare (Brownie et al., 2014; Buring et al., 2009). As contemporary health care delivery becomes increasingly complex, the World Health Organization (WHO) has emphasized the criticality of preparing healthcare students for teamwork environments through its development of a Framework for Action on Interprofessional Education and Collaborative Practice (WHO, 2010). A number of interprofessional education competency frameworks have been developed to assist with the implementation of interprofessional education within health professional education (Orchard et al., 2010; Curtin University, 2013; Interprofessional Education Collaborative Expert Panel, 2011; Thistlewaite et al., 2014).

Interprofessional student WIL can maximise placement opportunities and quality, while addressing service gaps in rural settings (Fatima et al 2018; Foley et al., 2019; Frakes et al., 2014). Despite the development and introduction of interprofessional learning frameworks, and the identified benefits, many health services have identified significant barriers to offering undergraduate Allied Health interprofessional experiences (Jacob et al., 2012).

Allied Health placements within regional and rural sites are often constrained by reduced numbers of allied health staff or having part time staff, limiting the capacity for discipline specific student supervision (Chipchase et al., 2012). Therefore, interprofessional WIL opportunities may offer a viable solution to this problem, however, there is a lack of clarity around the supervisory role for supporting interprofessional placements (Chipchase et al., 2012), and a need to address student assessment in the context of interprofessional education (Stone, 2010). A lack of agreement in distinguishing between discipline specific and generic (common across multiple health professions) key competency outcomes has been identified as a significant obstacle to the provision of genuine interprofessional WIL (Thistlewaite et al., 2014; Thistlewaite et al., 2010).

This lack of clarity around generic health professional key competencies limits supervisors' ability to adequately assess students within an interprofessional context (Greenstock et al., 2012; Thistlewaite et al., 2014). Historically, few professionals have been involved in assessment of students from other professions due to uncertainty around having required knowledge to undertake such assessment (Marshall & Gordon, 2010). This is despite many health professional skills crossing professions with stakeholders indicating a shared desire to improve assessment of generic skills such as effective communication, problem-solving, cooperation, commitment to life-long learning, and professional and ethical behavior (Hungerford et al., 2010).

Barriers to interprofessional supervision have been identified, with professional requirements mandating student assessment be undertaken by their own discipline (Crisp et al., 2006), as well as tensions between professions on how specific criteria such as clinical reflection should be assessed (Dunworth, 2007). Given potential benefits of interprofessional WIL (Ferns & Moore, 2012), there is a need to better understand how this could be achieved, particularly from the perspective of supervisors. One recent study, focusing on an international context, has demonstrated an approach to shared interprofessional student assessment highlighting collaborative learning and interprofessional authenticity that would not be achieved in a discipline specific approach (Skinner et al., 2020).

However, as Skinner et al. (2020) indicate, this interprofessional experience was based on an iterative shared supervisory model during an international placement experience, which may not reflect the perspectives of Allied Health staff in regional and rural settings who have not yet supervised students in an interprofessional context. Currently, there is limited literature in this area, particularly in the area of assessing students from different professions.

Current limited understanding of supervisors' perspectives and experiences reduces our ability to support supervisors to undertake supervision and assessment of Allied Health students from professions other than their own, thus failing to capitalise on potential WIL capacity, especially within rural and regional settings. This paper reports on regional Australian Allied Health clinical supervisors' perceptions of the enablers and barriers to engaging with interprofessional student placements. The findings could underpin development and implementation of interprofessional student placements within Allied Health undergraduate curricula, and how to best support clinical supervisors to successfully facilitate such placements.

METHODS

As this study aimed to develop deeper and richer understandings of clinical supervisors' perceptions of, confidence, and willingness to undertake clinical supervision and assessment of students from disciplines other than their own, a qualitative paradigm was chosen to frame the study. The qualitative paradigm has a central goal of seeking better understanding of the human world and in so doing acknowledges multiple constructed realities (Denzin & Lincoln, 2000). The qualitative paradigm encompasses a number of research approaches which share a core aim of understanding the human world (Higgs et al., 2007). From this range of approaches, phenomenological strategies which enhance exploration of individual experience and how individuals interpret their experiences (Smith et al., 2009) were chosen to guide this study. Thus, phenomenology of practice inquiries which particularly explore the human nature of professional practices (van Manen, 2014), provided an appropriate framework for exploration of clinical supervisors' perceptions of interprofessional supervision and assessment.

Ethics approval for this research was gained from the Charles Sturt University Human Research Ethics Committee and the Western NSW Local Health District Health Service Human Research Ethics Committee.

Participants

This study was undertaken at two regional New South Wales health services that had potential to offer interprofessional student placements. Allied Health clinicians who worked at either a small or medium sized regional health service and had supervised Allied Health students on WIL placements were invited to participate in the study. The selection criteria aimed to ensure that participants possessed relevant knowledge about clinical supervision in regional areas. Invitations to participate were distributed via email through senior allied health staff working at each site, to all allied health staff who met the inclusion criteria.

Nine clinicians who met the criteria volunteered to participate in this study. Eight were female and one was male. This is consistent with gender distribution in the Allied Health professions represented in this study (Australian Association of Social Workers, 2019; Australian Institute of Health and Welfare, 2013; Health Workforce Australia, 2014a; Health Workforce Australia, 2014b). The participants were from a variety of health disciplines including physiotherapy, occupational therapy, social work and dietetics. To maintain participants' anonymity and the confidentiality of the information they

provided, each participant was assigned a pseudonym for all reporting. Table 1 presents the number of participants, professions represented and health service location and type. To maintain confidentiality, pseudonyms have not been directly linked to professions.

TABLE 1: Study participants.

Location classification	Health service classification	Professions represented	Pseudonyms
Inner Regional City	Rural Referral Hospital and Health service	Physiotherapy, Occupational therapy, Dietetics	Abby, Anne, Helen, Jane, Michael, Simone
Outer Regional small/medium town	District Hospital and Health Service	Dietetics, Physiotherapy, Social work.	Julie, Lucy, Tracy.

Data Collection

Semi-structured focus groups were undertaken by two of the researchers to explore participants' perceptions of confidence and willingness to undertake clinical supervision and assessment of students from disciplines other than their own. A key strength of focus groups is their explicit use of group interaction to produce insights that would otherwise be less realised by individual participants (Morgan, 1997). The synergistic effect of group discussion results in building of ideas that might not occur in individual interviews, as participants react to responses from other group members.

Two focus groups were held, one at each site, with one group consisting of six participants and the other three participants. The imbalance in numbers between the groups was due to differing size of the health services, with one being located within a large regional town and the other within a small rural location, as well as staff availability at the time of the focus group. The focus group discussions lasted for one hour and with participants' permission were audio recorded and the recordings transcribed verbatim to form texts for subsequent interpretation.

Data Interpretation

The process of interpretation occurred in all stages of this study, including data collection. All data generated, including researchers' observations, field notes and interview transcripts were coded within a phenomenological tradition including holistic, selective and detailed readings of and reflections on the texts (van Manen, 2014). Consistent with phenomenological approaches to text analysis, each text was listened to and read several times to uncover the paragraphs, statements or phrases that were particularly revealing about the experience of clinical supervision in general and thoughts around interprofessional supervision more particularly. Those paragraphs or phrases that were particularly evocative were saved as rhetorical "gems" and were used to develop and write the findings (van Manen, 2014). The coding process was completed independently by three of the authors (KS, MS, NP), followed by joint discussions and a final analysis and synthesis by the fourth author.

RESULTS

Analysis of the focus group discussions revealed three super-ordinate themes. These were: 1) Introducing the interprofessional lens early; 2) Tapping into unique possibilities; and 3) Setting up for success – balancing challenges with opportunities.

Theme 1: Introducing the Interprofessional Lens Early

Participants described the benefits of exposing students to interprofessional practice in their initial clinical placement opportunities. It was seen as important by participants, as it set the scene for future clinical experiences, enabled students to have a better understanding of how the health system works and the differing roles of each health professional. Jane highlighted this point when discussing the opportunity for junior students to develop a broader understanding of the health system “they’ve actually been very enthusiastic to see what everyone else does, because so often, they’ve got no idea what an OT [occupational therapist] does. What does a dietician do? They don’t know. What does a pharmacist do in the hospital?”

Jane also felt that students may be more enthusiastic in learning about the different health professional roles and how they work together within the health system if they had interprofessional experiences early in their student journey. Enabling students to have a more global understanding of the health system through early interprofessional opportunities may allow students to build a strong foundation of interprofessional healthcare practice and support the development of a wide range of skills across their placement experiences.

Participants also spoke about the value of having more junior students involved in interprofessional opportunities, as long as these experiences are tailored to suit the skills and knowledge of the particular year group. This is illustrated in Anne’s excerpt.

Particularly that second year placement...so much that is about just orientating yourself to how does the health service function? There’s not as many of those strong clinical skills that are needed, whereas when you are in year four it is all about managing your workload, get through your patients.

Anne recognised that it may be more difficult to supervise students within an interprofessional context in their final years because the placement is often focused on demonstrating discipline specific patient care, whereas in earlier years the more generic skills required in the health service can be assessed. These generic skills could be assessed by a range of different health professionals. This point was echoed by Michael, who indicated he wouldn’t feel confident to assess specific clinical skills of final year students from a discipline other than his own.

I would be happy to have dietetic students or any students at that early stage... I would be much more concerned about having a dietetics or a speech student in their last year of their placement when they’ve got to have really advanced skills and I’ve got no idea

Michael highlighted the difficulty that some clinicians may encounter if they were asked to supervise and assess final year students within an interprofessional context, when there is more emphasis on students demonstrating clinical knowledge and skills relevant to their specific discipline. As such, health service staff may be better placed to support interprofessional experiences as an initial placement experience.

Theme 2: Tapping into Unique Possibilities

Interprofessional placement supervision was seen by the research participants to open up unique possibilities. These possibilities included increased supervision capacity, learning more about other professions and a pathway into clinical supervision for junior clinicians. Participants identified that shared interprofessional placements may open opportunities to expand placement capacity, as can be seen by Abby's comment "if you know it's not such a big commitment, you've only got them [students] Monday, Wednesday, Friday, you're probably more likely to agree to take them than if you think I've got them for five weeks." Abby indicated she would be more likely to accept students on placement if there were opportunities for them to spend time with other health professionals during the week, so that she could have a break from supervision. This suggests that facilitating shared interprofessional supervision as part of a student placement may open up more placement opportunities for students.

Alongside the benefits to students, participants also discussed specific benefits for clinicians in having students from other disciplines spend time with them clinically. Lucy could "see it being a benefit as a clinician to get an insight into what would you do?...If it's a dietician, okay, what would you do with this client of mine who has a total knee replacement?" Lucy made the point that shared knowledge is important for person centred care and while it was recognised there were challenges with specifically assessing students from other disciplines on their clinical knowledge, this interprofessional sharing of knowledge enables discussion of potential referral pathways and intervention options for clients that may not have been considered if the interprofessional supervision had not occurred.

Increasing placement capacity was another aspect highlighted by participants. This could be achieved through larger departments within a site undertaking a range of basic skills with students within an interprofessional context, therefore freeing up smaller departments to focus on student learning within specific areas of clinical care.

Physiotherapy has a bigger department. Dietetics and speech therapy are smaller, so if I have to sit with someone and go through how to use email, that means that no one is being seen whilst I am doing that. So if that's already covered, and I can say right, we can go straight to the ward, it's less time (Simone).

It was perceived by participants that orienting students from different disciplines together within an interprofessional framework meant that duplication of tasks by different departments could be minimised, resulting in both time efficiencies and greater learning opportunities for students.

Interestingly, participants also indicated other benefits for clinicians. It was perceived that the ability to facilitate interprofessional placements at their sites provided greater opportunities for more junior clinicians to develop their clinical supervision skills in a supported way, as can be seen by Michael's statement "for a supervisor who is new to clinical supervision...it probably would be a good first step exposure, short term, easily marked ...because you don't expect juniors to supervise solely or wholly".

Michael highlighted that interprofessional placements often have more than one supervisor responsible for the student, and that the student assessment has a different emphasis compared with final year placements. This would provide opportunities for clinicians who have not supervised students to develop these necessary skills through appropriate mentorship and guidance, before being responsible for assessment of final year students. Abby expanded on this and identified that this benefits not only the junior clinicians but also the more experienced clinical supervisors when she suggested "it gives

those senior clinicians a chance to watch how the junior clinicians do it...is there something that I need to talk to them about before we give them a five weeker...a little practice run.”

Abby illustrated how this approach can benefit all staff at the health service, by enabling a structured approach to professional development in clinical supervision that otherwise may not occur. Michael explained further “It is an opportunity to not target the senior or the regular supervisors but to target an intermediate level, to go, this is what we’re proposing and we will provide you with training and support.”

Supporting clinicians with limited clinical education experience by utilizing shared interprofessional supervision has the potential to create opportunities to increase student placements at health sites that may not otherwise have capacity due to limited availability of senior clinical supervisors. It also has capacity to address some challenges in supervision, career pathways and progression for rural allied health practitioners.

Theme 3: Setting up for Success – Balancing Challenges with Opportunities.

The participants acknowledged existing challenges in implementing interprofessional approaches to student placements. However, participants indicated these could be mitigated by ensuring placements were well organized and structured. “It needs to be set up properly. Maybe a coordinator or project officer to manage it. Clear guidelines” (Jane).

Jane also highlighted the importance of a coordinated approach, with clear guidelines to ensure supervisors and students have a shared understanding. If this was not implemented, it could increase challenges for both students and staff with not having a clear understanding of the aim of the experience. As Simone discusses “if they [students] think they are coming for a physiotherapy placement and they’re with me...I am not going to be talking anything physiotherapy related...so they’re going to be really disappointed.” It is important that students understand the purpose underpinning the interprofessional experience, in order for them to gain the most out of the opportunity, and to manage their expectations. The participants saw this as especially important when students were being supervised by someone from another profession.

Participants also raised concerns when supervising students from another profession about how to determine the student’s level of clinical knowledge and the appropriateness of any contributions the student may make to client care. Jane explained:

My concern would be if another discipline had a dietetic student and asked them what would you do for this person with constipation, and the student gave a totally inappropriate answer, but that physiotherapist or speech pathologist doesn’t know that’s a completely wrong answer. Then they might take that and try and implement it into their practice and it’s the wrong clinical information that they’re giving.

Participants perceived this would be particularly challenging in relation to student assessment if the focus was on discipline specific clinical reasoning. This is also echoed by Abby “but if they’re struggling, then they need that one on one with someone in their discipline”. Participants indicated there should be clear mechanisms for students to be supported by a supervisor from their own discipline if specific issues arose that participants did not feel confident to manage.

To facilitate effective interprofessional learning experiences, the participants suggested careful consideration be undertaken of the types of assessment that would be appropriate within an interprofessional context. Also discussed was the support required from the educational institution, including the potential to have an external person who was ultimately responsible for student assessment in interprofessional WIL placements. This is illustrated by Michael:

If...all of the assessment side of it was mostly off site, that would make me a lot more interested in it...You could feed back to them, you could tell them, you can email them what happened today...you might confer about some of the soft skills side of things. Yes, they were punctual and yes they did communicate well interprofessionally...That would make it so much easier, time wise.

The participants felt that the assessment of students' soft skills such as communication, problem-solving, collaboration, and professional behavior, was more generic across disciplines, and therefore it was more realistic for participants to contribute to these aspects of the assessment of a student from another profession. It was deemed more appropriate that discipline specific aspects were assessed by a person working either within the health site or at the educational institution who had expert knowledge in these areas.

DISCUSSION

This study explored some significant issues for interprofessional supervision and assessment in WIL, as perceived by Allied Health clinical supervisors working in regional Australia. Phenomenological analysis of the focus group discussions resulted in identification of three key themes: introducing the interprofessional lens early; tapping into unique possibilities; and setting up for success – balancing challenges with opportunities. The three themes, whilst exploring issues, also raised potential benefits and solutions.

Interprofessional learning opportunities are often provided in first year, aiming to locate such learning early in order to combine students' professional role development with development of other role awareness (Cooper et al., 2005). Whilst this concept is consistent with participant comments, this and other examples of early interprofessional learning are often undertaken in a simulated university setting (Lapkin et al., 2013), providing a theoretical rather than applied opportunity.

The study participants identified that they would value early interprofessional WIL placements, with second year students specifically identified on the basis of having foundation knowledge but not yet being required to demonstrate strong profession specific clinical skills. Whilst students may not yet understand or appreciate the value of working with other health professionals, they are also not fixed within their own role, and may be more open to learning about other roles, how the health system works and the place of teamwork in patient care. Attrill et al. (2018) propose that interprofessional learning opportunities undertaken early in students' course programs may provide fresh perspectives of others that enhance cooperative working, rather than reinforcing the dominant perspectives of professional socialisation into their own profession. Cooper et al. (2005) found that, at least in the university setting, students felt that "starting early is the best way" (p. 502). Early interprofessional experiences assist students to develop capacity to bridge disciplinary divides, and work effectively as a team (Aggar et al., 2020).

A further benefit of early interprofessional WIL placements revealed by this research was the emphasis on learning how health systems and health teams work, with a focus on generic soft skill development.

Participants felt more confident in their capacity to supervise and assess learning across different professions when there is less emphasis on highly weighted, discipline specific assessment and more emphasis on competencies that are generic to all disciplines. Additionally, acceptance by students of supervision and assessment by other professions may be enhanced with early introduction of interprofessional WIL placements (Chipchase et al., 2012).

This research also identified a range of broader benefits of interprofessional supervision in WIL. These benefits include expanded placement capacity, interprofessional learning for staff and students alike, and efficiencies resulting from improved coordination of student placements. These broad ranging benefits of interprofessional supervision offered advantages to a range of stakeholders: clinical supervisors, students, and early career professionals. It also offered potential benefits across a range of different settings.

Workload pressures and lack of time have been identified as challenges for clinicians undertaking student supervision (Davidson et al., 2008; Hall et al., 2015; Thomas et al., 2007). Participants indicated that they would be more likely to accept a student if the supervision was shared in ways that reduced the time commitment. As such clinical supervisors who work within multiple smaller institutions across a region were potentially able to benefit from shared supervision with other health practitioners, lessening the load more than if they were the sole supervisor. This shared load could lead to expanded interprofessional WIL placement capacity in a range of ways: part time staff could formally share the supervision; supervision by staff working across institutions, as is common in rural settings; staff with caseloads that include aspects considered not appropriate for students could supervise part of a student's placement; sites with part-time Allied Health services could still consider student placements and students could have placements across more than one site or service. This increased placement opportunity in rural health services has potential to positively influence allied health professional recruitment and retention in these sites (Crowe & Mackenzie, 2002; Fatima et al., 2018; McNair et al., 2005).

Participants also reflected on the possibilities for mutual interprofessional learning between both supervisors and students. The participants in this research indicated that improved insight into other professions on the part of the clinicians would enable efficiencies and improve patient centred care. This finding is consistent with Attrill et al (2018) who identified that interprofessional placements provide genuine opportunities for mutual learning and reciprocity between different professions. Skinner et al. (2020) also describe collective and collaborative learning, with positive impacts that extend beyond the clinical placement context to influence the supervisor's own clinical practice.

Participants in this research described a range of potential benefits of interprofessional supervision relating to sharing generic supervision activities reducing duplication and enhancing efficiencies for the organisation. Jacob et al. (2012) also identified lack of knowledge of other student placement activities within the organization and duplication and repetition of a large range of administrative, orientation, training and education activities by individual disciplines. Our research highlighted that time efficiencies achieved in this way would allow limited supervisor time to be focussed on discipline specific supervision. For example, smaller departments may be able to outsource some of the more generic supervisory activities such as orientation activities, understanding aspects of how the health system works, and using the IT systems, to larger departments that would be conducting these sessions for their students, thus reducing duplication and harnessing interprofessional learning opportunities for the students.

In exploring the challenges and benefits of interprofessional assessment in WIL, participants identified opportunities for early career professionals with no or little supervision experience to develop the skills to become future disciplinary supervisors, by engaging in shared interprofessional supervision and assessment. The ability for more senior clinicians from another profession to provide clinical supervision and mentorship to early career clinicians as they supervise and assess students in common or core competencies, would enable clinical supervision skill development in a broader range of Allied Health clinicians and may increase capacity and confidence of early career clinicians to take students from their own discipline in the future. Such career maturation opportunities may not otherwise be readily available to junior clinicians who work in smaller settings with few other professionals from their own discipline. This may help with retaining allied health workers by addressing some of the identified challenges around adequate supervision and support, structured career pathways and progression (Worley, 2020, p.4). The development of a larger pool of student supervisors through shared supervision and mentorship provides scope for sharing the supervisory load between more professionals, increasing student placements in established sites, and also creating student placements at regional and rural health sites that may not otherwise have capacity due to lack of senior clinical supervisors.

It has been demonstrated that registered Allied Health practitioners in Australia may be uncertain of their ability to assess students from another Allied Health profession, even for common competencies (Marshall & Gordon 2010). In contrast, this study identified that in both larger and smaller regional health sites, Allied Health practitioners were open to assessing common or core competencies for students from another Allied Health discipline, particularly for early year students. This assessment could involve generic competencies that are common across Allied Health, such as communication, problem-solving, collaboration, and professional behavior, rather than discipline-specific skills and knowledge. Confidence in assessing generic skills in students was consistent with findings of Skinner et al. (2020). The acceptance of shared assessment by Allied Health accreditation bodies may present a barrier, but there are emerging precedents for shared supervision across professions. For example, the Australian Physiotherapy Council accreditation standards require that "Students are supervised by suitably qualified and registered physiotherapy and health practitioners during clinical education" (2017, p. 4).

This study identified a range of possible models for interprofessional WIL. Study participants proposed several possibilities for shared interprofessional supervision: agreeing to share students across disciplines; a professional supervising a student from a different Allied Health discipline with the university providing discipline specific supervision and bringing together students from different professions already on placement into a structured interprofessional experience. This breadth of possibilities, interpretations, models and terminology in interprofessional WIL placements has previously been reported (Davys, 2017), and is a significant issue, as uncertainty about what interprofessional WIL placements might entail has been an impediment to their establishment and sustainability (Davys, 2017). The participants flagged this issue but felt this could be mitigated by structured and organized placements, with a coordinated approach and clear guidelines for all stakeholders as to the aim and focus of the placement. This is consistent with findings on the importance of a common understanding between the interprofessional supervisors of both the concept of the interprofessional experience (Jacob et al., 2012) and the focus of the assessment within that experience (Skinner et al., 2020).

Participants also raised the challenge of how they would know whether the contributions of a student from another profession were appropriate, and felt they lacked confidence to assess discipline specific

clinical reasoning. In raising this challenge, they also offered solutions that have support within the literature. These included clear mechanisms for students to be supported by a supervisor of their own discipline (Chipchase et al., 2012) and, agreement around which aspects of student performance the interprofessional supervisor would assess, these aspects being based on generic soft skill development common across the Allied Health professions (Skinner et al., 2020).

Earlier interprofessional WIL placements may also help to address some of the concerns expressed around being able to determine the appropriateness of the clinical reasoning of a student from another profession. Early in a student's learning, contributions are more likely to consist of identifying the role their profession might play in the situation rather than high level clinical reasoning discussions. It would be important to have placement structures in place for such student contributions to lead to initiation of patient referrals, rather than direct intervention by the student, again reinforcing an emphasis on careful and detailed planning (Davidson et al., 2008).

LIMITATIONS AND FUTURE RESEARCH

This study identified that in both larger and smaller sites, regional Allied Health practitioners were open to supervising students in an interprofessional WIL placement, and assessing common competencies for students from another Allied Health discipline, with certain conditions such as year level of the students. However, these regional study sites and the range of Allied Health practitioners who participated in this study may not be representative of every Allied Health discipline nor every regional or rural site. The participant characteristics varied between the sites in terms of the range of practitioners available, whether they worked part-time or full-time, and gender and experience of the practitioner. This data was not formally collected to avoid the risk of potentially identifying practitioners. The lack of quantitative data to characterize sites or professions, necessary especially in smaller towns for confidentiality, might also be considered a limitation of the study in terms of generalizability.

Further, this study used phenomenological approaches with resultant low number of participants. However, these methods result in richer data, and larger numbers of participants may not identify additional themes, as data saturation may occur at lower numbers. Whilst these limitations may mean that the results are not generalizable, the information does support and add to similar findings from a different rural context (Jacob et al., 2012).

CONCLUSION

In researching regional Allied Health clinical supervisors' perceptions on the enablers and barriers to engaging with interprofessional student WIL placements, this study established that Allied Health practitioners in regional sites were open to supervising students in an interprofessional WIL placement, and assessing common competencies for students from another Allied Health discipline. The study identified key elements that may contribute to successful Allied Health interprofessional WIL placements in regional and rural settings, including timing the placement early in the student learning, using shared interprofessional supervision to mentor the development of supervisory skills in junior clinicians, and ensuring clarity around the purpose and processes of each individual placement. These findings provide the foundation for a unique interprofessional model of WIL suitable to regional and rural locations.

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