Novice practitioners' perceptions of engaging in a specialist mental health and addiction transition to practice programme: An interpretive description study

Suzanne May Patterson

A thesis submitted to Auckland University of Technology in partial fulfilment of the requirements for the degree of Master of Health Science (MHSc)

2022

School of Clinical Sciences

Faculty of Health and Environmental Sciences

Primary Supervisor: Dr Ellen Nicholson

Secondary Supervisor: Professor Brian McKenna

Abstract

Transitioning from student to healthcare professional is recognised by many as stressful. Structured transition to practice programmes have been developed to ease the transition journey and support novice practitioners' successful entry to professional practice. While there is a significant body of literature examining the benefits and effectiveness of transition programmes within nursing, there is little available research dedicated to the allied health disciplines. Specialist areas of practice, such as mental health and addiction, have received even less attention. This interpretive descriptive study sought to uncover novice allied health practitioners' perceptions of completing a specialist mental health and addiction transition to practice programme with a post-graduate academic qualification component in Aotearoa New Zealand. Investigating the experience of clinicians completing transition programmes is intended to inform disciplinary understanding and advance practice within this important area of professional practice.

Nine social work and occupational therapy participants were recruited from graduates of an allied health specialist mental health and addiction transition programme. Two focus group interviews were conducted, audio recorded, and transcribed. Data were analysed using Braun and Clarke's (2006) six-step process for thematic analysis from which three key themes were constructed: *Making the big leap*; *Feeling supported*; and *Fighting the old ways*.

This study revealed the transition programme facilitated novice allied health practitioners successful transition to mental health practice through the provision of specialist mental health knowledge, skills, and engaging organisational and professional support. The findings confirmed novices' progress through transitional stages, highlighting the importance of acknowledging novice practitioners as 'novices' with needs unique to being a novice at each of these stages. An important finding was that the transition programme constructed a protected space for novices that eased perceived stressors and challenges of transition. Peer support was considered a significant source of support contributing to novices feeling protected. Additionally, participating in a transition programme with a strong recovery focus advanced novice allied health practitioners' knowledge and skills for recovery-oriented mental health practice.

The outcomes of this research suggest there is much to learn from exploring the experiences of novice allied health practitioners undertaking transition programmes. The implications for practice, education, and the mental health sector, drawn from this research, offer insight into initiatives and practical strategies to enhance the transition to practice programme experiences for future novice allied health practitioners. Areas for ongoing research are considered.

Table of Contents

List of Tables

List of Figures

Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

Signed:

Date: 23 June 2022

Acknowledgements

Good things take time – or so they say. Completing this thesis has certainly taken time; and it would not have happened without the encouragement, support, and assistance of several key people that have journeyed alongside me or contributed to my life in some way while undertaking this research project.

First and foremost, I would like to thank the participants who shared their time, insights, and experiences, and without whom this research would not have been possible. You inspired me with your passion and motivation for the work you do every day. Listening to your experiences and reflections on practice left me feeling hopeful, energised, and sure that the future of mental health practice is in good hands when we have practitioners, like yourselves, supporting whaiora and whānau accessing mental health and addiction services.

To my supervisors, Dr. Ellen Nicholson and Professor Brian McKenna, a heartfelt thank you. There must have been times that you were wondering if we were ever going to get to this point! Thank you for your patience and the unfailing encouragement as we have travelled this extended path together. Your guidance, wisdom, and critique has been appreciated and valued – I have been fortunate to have you both on my team and literally would not have completed this thesis without you. I also could not have done this without the unwavering support of my AUT colleagues and want to thank Dr. Daniel Sutton and Michele Yeoman for sharing their knowledge, ready ears, and kind words when I needed them. And, of course, Dr. Shoba Nayar for her timely and expedient transcribing skills and proofreading of this thesis.

Special thanks must go to the Graduate Women North Shore Charitable Trust. I am grateful for the scholarship and financial contribution that they made towards my research project in the final year of my study.

And last, but definitely not least, I thank my wider family and friends for putting up with me being unavailable while I have been completing my research, and for the encouragement and support to keep me going. I am especially grateful to my daughter Maddie and my husband Mike for their unconditional love and support, without which I would not have made it through this process. I cannot thank you both enough for being there for me, giving me the time to complete my work, and for making this possible. Thank you.

Ethical approval to undertake this study was provided by Auckland University of Technology Ethics Committee on 29th October 2018. Application number 18/383 (see Appendix A).

Chapter One: Introduction

In 1998, the now infamous Mason Report acknowledged the need for significant change to mental health and addiction service provision and delivery in Aotearoa New Zealand, highlighting a workforce that was insufficiently supported and skilled to meet the changing demands of the mental health and addiction sector (Mason, Ryan, & Bennett, 1998). The report further highlighted that transformational change was required at systemic, cultural, political, and philosophical levels to facilitate improved performance and better outcomes for service users and their families (Mental Health Commission, 2007, 2012). In Aotearoa New Zealand, improved service provision within mental health and addiction has been progressed through national strategy such as *Rising to the Challenge,* the Mental Health and Addiction Service Development Plan 2012-2017 (Ministry of Health, 2012) and policy such as the Blueprints for mental health services (Mental Health Commission, 2007, 2012). While significant improvement has occurred in the quality and access to mental health services for consumers as a result of these coordinated national initiatives, it is acknowledged that improvements across the wider sector can still be made (Ministry of Health, 2012; New Zealand Government, 2018), including within the area of workforce development (Ministry of Health, 2005; Smith & Jury, 2017).

This thesis describes the research process and findings from a study that explored the perceptions of novice allied health practitioners who completed a specialist mental health and addiction transition to practice programme in Aotearoa New Zealand. The study aimed to discover participants' experiences of the programme and how participation in the programme influenced their transition to professional practice. This introductory chapter provides an outline of the context for the research, as well as an overview of the study aims, research question, definitions of key terms, and the potential contribution of the research. The remainder of the chapter presents the underlying professional values and beliefs of the researcher, the rationale for undertaking this study, and closes with an overview of the thesis structure.

Research Context

The mental health and addiction workforce is in crisis. Pressure on mental health systems, service delivery, and the mental health workforce is increasing as the numbers of people experiencing mental health disorders globally continue to rise (World Health Organization [WHO], 2013, 2019a). High levels of population growth and increasing numbers of people accessing mental health and addiction services, alongside an ageing workforce and workforce shortages, are perpetuating this crisis (Te Pou o te Whakaaro Nui, 2017a; WHO, 2013). Wider

global threats to mental health (e.g., poverty, the impact of colonisation, limited access to mental health care, education and occupational opportunities, natural disasters and international pandemics) have also placed increased demands on communities, governments, and organisations to improve mental health knowledge and service provision to facilitate the mental health and wellbeing of people requiring mental health support (WHO, 2019a). Quality, responsive mental health services that meet consumers' needs and facilitate the recovery of people experiencing mental disorders form key components of the WHO (2013) Mental Health Action Plan 2013-2020. Therefore, building a mental health workforce capable of providing quality mental health care that consumers require and deserve has been recognised as being of global concern (WHO, 2019b).

In Aotearoa New Zealand, the recent workforce stock take, compiled by Te Pou o te Whakaaro Nui (2017a), estimated there are approximately 12,500 full-time equivalent (FTE) staff currently working in mental health and addiction services. While the workforce has increased significantly from 9,500 FTE since 2015 (Te Pou o te Whakaaro Nui & Matua Raki, 2015), reflecting the wider international context, there is a projected shortfall between the number of staff employed in this sector and the workforce capacity required to adequately meet predicted consumer need (Te Pou o Whakaaro Nui, 2015). Growing the allied health workforce in mental health and addiction services is considered a vital strategy to address this impending crisis (Pack, 2010; Te Pou o te Whakaaro Nui & Matua Raki, 2015). The need for increased emphasis on attracting and retaining allied health workers within mental health and addiction services has been highlighted (Smith & Jury, 2017; Te Pou o te Whakaaro Nui, 2015, 2017a).

Imperative to bring about change and address the workforce crisis is the targeted mental health education of healthcare practitioners. Integrating mental health content within both undergraduate and postgraduate healthcare education programmes is deemed critical to strengthen the future mental health workforce (WHO, 2013). Within the Aotearoa New Zealand context, and influenced, in part, by these collective contextual issues, postgraduate transition to practice programmes have been established to advance mental health knowledge and skills within the nursing and allied health disciplines since 1995 and 2003 respectively (Pack, 2010; Smith & Jury, 2017; Te Pou o te Whakaaro Nui, n.d.). An example is the New Entry to Specialist Practice (NESP) programme for allied health practitioners offered by Te Pou o te Whakaaro Nui which is designed to facilitate practitioners transitioning to mental health and addiction practice (Te Pou o te Whakaaro Nui, n.d.). Programmes such as NESP form a key part of the national workforce development plan in Aotearoa New Zealand to achieve "the right people, with the right skills, in the right place, at the right time" (Ministry of Health, 2005, p. 3) working in mental health and addiction services.

Overview of the Research Aims and Question

Given the critical nature of transition programmes as a workforce development initiative, the aim of this study was to explore novice social work and occupational therapy practitioners' experiences of participating in a specialist transition to practice programme. The intent was to deepen knowledge and develop understandings of participants' experiences so as to inform and progress both allied health practice initiatives and transition programme provision in Aotearoa New Zealand, specifically within the mental health and addiction practice context. The overarching research question was: *What are novice allied health practitioners' perceptions of engaging in a specialist mental health and addiction transition to practice programme in Aotearoa New Zealand?*

It is established in the literature that transitioning from undergraduate student to health professional can be a complex and stressful process (Melman, Ashby, & James, 2016; Moriarty, Manthorpe, Stevens, & Hussein, 2011; Seah, MacKenzie, & Gamble, 2011). The transition period has been characterised as a time of intense professional development and personal growth (Hunt, Lowe, Smith, Kuruvila, & Webber-Dreadon, 2016; Moriarty et al., 2011; Quick, Forsyth, & Melton, 2007; Tryssenaar & Perkins, 2001). It is also widely recognised that transitions can present considerable challenges and that novice practitioners may require additional support over this period to successfully enter clinical practice (Melman et al., 2016; Moorhead, 2019; Seah et al., 2011). As a result, there have been many studies published exploring this subject in the discipline of nursing (e.g., Henderson, Ossenberg, & Tyler, 2015; Jewel 2013; Kumaran & Carney, 2014; Pfaff, Baxter, Jack, & Ploeg, 2014). However, concerns have been repeatedly raised that there is a relatively small body of literature exploring the transition to practice experiences of allied health practitioners (Glassburn 2020; Melman et al., 2016; Smith & Pilling, 2007).

Understanding the transition period, the process of transition, and the needs of novice allied health practitioners during transition is essential to ensure the successful introduction to clinical practice for allied health disciplines (Glassburn, 2020; Melman et al., 2016; Tryssenaar & Perkins, 2001). Lloyd, King, and Ryan (2007) suggested this understanding is even more essential for allied health practitioners transitioning to specialist practice areas, such as mental health and addiction. Previous research has identified a myriad of challenges novices encounter during transition including feeling unprepared for practice, lacking confidence and competence, novice expectations of transition, insufficient supervision or orientation, and developing professional identity during transition that can negatively influence their successful entry to the workforce (Robertson & Griffiths, 2009). Specialist transition to practice programmes have emerged as one solution to support novice practitioners and ease the

challenges of transitioning to practice, alongside meeting workforce development needs in the mental health and addiction sector (Ministry of Health, 2005; Smith & Jury, 2017). This is a growing trend internationally and an initiative well established in Aotearoa New Zealand.

Transition to practice programmes often comprise of education and teaching/learning sessions, informal supervision or mentoring, structured supervision or preceptorship; or programmes that offer a combination of these components. More comprehensive structured transition programmes also include opportunities for applying learning in practice, protected time to complete programme activities, and critical reflection elements to enhance novices' skill acquisition in practice. Despite variation in the composition of transition programmes, research has shown transition to practice programmes are effective vehicles to support novice practitioners successfully navigating the transition period (Missen, McKenna, & Beauchamp, 2014; Proctor et al., 2011; Rush, Janke, Duchscher, Phillips, & Kaur, 2019; Te Pou o te Whakaaro, n.d.). Perhaps, unsurprisingly, given the size of the nursing workforce, there is a significant body of research relative to the nursing profession in this area. While this research sits in a similar context, and may be a useful point of reference, the experiences of novice nurses may not be directly applicable or correlate to the experiences of the allied health disciplines transitioning to the mental health and addiction workforce. As such, examining nursing transitions has not been pursued within this thesis. Rather, exploring the experiences of novice allied health practitioners undertaking transition to practice programmes is considered essential to advance allied health disciplinary knowledge pertaining to resources and strategies that may be required to overcome the difficulties these particular practitioners encounter and, therefore, progress understanding as to how transition programmes can further contribute to reducing transition challenges for the allied health disciplines.

Critical to understanding the context for study, the participants in this study were allied health graduates of a mental health and addiction transition to practice programme (New Entry to Specialist Practice; NESP) funded by the Ministry of Health and provided through a tertiary institution in Aotearoa New Zealand. A summary of fundamental aspects of this programme are outlined below, while a more detailed description of the NESP programme, as it existed between 2015-2017, is provided as Appendix B. The NESP programme runs over one academic year of the university calendar. A core element of this transition programme is that there is an academic postgraduate level study component for which graduates receive a postgraduate certificate upon successful completion of the course. The programme comprises two semester-long academic papers, each based on core elements of recovery-oriented practice and mental health and addiction theory and principles. There are applied learning opportunities over four weeks of face-to-face on-campus teaching blocks, study days, and supported clinical

experience through applying learning in the workplace with supervision and preceptor support. Additionally, there is an online reflective practice portfolio that trainees complete to evidence professional progression and developing competence (Te Pou o te Whakaaro Nui, n.d.).

Despite transition programmes playing an important role in supporting novice allied health practitioners' successful entry to mental health practice, and having been linked to improved retention of clinicians (Smith & Jury, 2017; Smith & Pilling, 2007; Te Pou o te Whakaaro Nui, 2017b), little is known about the transition programme experiences of novice allied health practitioners both internationally and in Aotearoa New Zealand. Even with understanding that these programmes positively contribute to novices' mental health knowledge and better equip practitioners to practice in mental health and addiction services, there are likely gaps in sector knowledge as to how these programmes influence the successful transition to mental health and addiction practice. As currently little is known about this phenomenon, an interpretive description approach was selected to uncover participants' experiences of the transition programme to enable a deeper understanding of how the programme facilitated the transition. The goal of interpretive description is to generate new knowledge and insights that can be used to inform and guide clinical practice (Hunt, 2009). Therefore, understanding transition programme experiences, from the perspectives of practitioners engaging in these programmes, has the potential to inform policy, clinical practice, and improve transition programme educational practices. Research exploring this area of practice also has the potential to advance workforce capacity in the mental health sector and facilitate improved outcomes for people accessing mental health services in Aotearoa New Zealand.

Key Terms

There are several key terms referenced within this thesis: allied health, novice practitioners, and transitions. Defining these key terms is necessary to understand what they mean in relation to this thesis as they are central to the research discussion. Allied health professions are often described in terms of what they are not, rather than what they are. In Aotearoa New Zealand the allied health professions are defined as "health professionals outside of the medical, nursing and midwifery and kaiawhina professions" (Hogan, 2021, p. 3). Within the context of this thesis, the term allied health refers to both occupational therapy and social work practitioners.

'New-graduates' and 'novice practitioners' are terms utilised interchangeably within healthcare literature to refer to clinicians who have completed their professional undergraduate training and are in their first 1-2 years of professional practice. Novice

practitioner has been applied in this thesis and recognises that some clinicians transitioning to practice also bring life experience or clinical experience from working in other areas of health, education, or social services rather than transitioning from simply being a graduate student to healthcare practitioner.

Transitions have been defined as "the process or a period of changing from one state or condition to another" (Oxford Dictionary, n.d.). In health care practice, the transition often represents a change of status from the role of student to professional practitioner. A concept relevant to transitions in the literature is the idea of liminality. Liminality refers to a state of change and being on the threshold of developing a new identity; yet still being in-between one stage and the next, that is often accompanied by a sense of uncertainty (Crane & Abbott, 2021; Evans & Kevern, 2014; Hurlock et al., 2008; Morgan, 2019). This is reflective of the stage of professional development of participants in this study.

Position and Perspective of the Researcher

Thorne's (2008) interpretive description methodology, which underpins this study, encourages sharing the disciplinary position and professional interests of the researcher to situate the research within both disciplinary and personal contexts. It forms an important part of the scaffolding for an interpretive description study (Thorne, 2008). As part of managing reflexivity, at the outset of this research project, I compiled a written reflection of beliefs as a clinical educator, the needs of new graduate clinicians, assumptions about mental health practice, and the experiences of trainees undertaking specialist transition to practice programmes. The purpose was to raise awareness of any personal and professional biases in order to consider how these might influence the research question or the study design and processes. This section details some of the professional values and beliefs I hold that may have influenced the lens applied to this study and outlines why this area of research is of interest.

I have had a relatively significant history of working as an occupational therapist in mental health and addictions practice both in Aotearoa New Zealand and the United Kingdom. Being interested in mental health had been one of the driving factors that encouraged me to consider occupational therapy as a profession in the first place. I loved the hands-on approach, the simplicity and the magic in the power of 'doing', and how supporting others to engage in occupations and activities can facilitate wellbeing and transform their lives. I spent the majority of my clinical practice career working in either forensic or child and adolescent services. Knowing that I could make a significant difference in people's lives that may reduce the impact of mental illness was a strong motivator to keep developing my practice and to better support the consumers with whom I was working. As I gained experience, I took on

professional supervisory roles, supporting mental health clinicians in their professional development journeys. The clinical educator role I currently occupy brings together my love of occupational therapy, my knowledge of mental health practice, and my enjoyment of supporting clinicians in their professional practice. These perspectives fit well with this research project, as I bring clinical practice, occupational and education lenses with me into this study.

In recent years, mental health service delivery has had the spotlight turned upon it. As society has become increasingly aware of the importance of maintaining wellbeing for everyday life, mental health has become far more mainstream, including how its absence can be so debilitating and stigmatising. This has become particularly evident in the wake of significant earthquakes and disasters in Aotearoa New Zealand over the past decade, including the current COVID pandemic and living within the resultant restrictions. Addressing the effects of mental ill health, or the absence of wellbeing, has become more critical than when I started out on my own professional journey. My belief is that in today's mental health climate consumers need, more than ever, appropriate care and support from hopeful and creative clinicians to manage the symptoms of their illness, build wellbeing, and enrich their quality of life. I see occupational therapy and social work clinicians as playing a vital role in this space and in the lives of consumers accessing mental health and addiction services. Clinicians offering consumers this level of care may need additional support and resources themselves to continue to provide this service.

Better supporting novice practitioners, to enable them to meet the changing demands of consumers and the mental health sector, has been a key motivator for this research. Coming to the decision to undertake this study was a natural extension of my clinical educator role. In conjunction with my own beliefs about mental health and wellbeing, I wanted to understand more about how the transition period was experienced by novice practitioners. I was at a point in my own professional journey where I was questioning how I could extend and develop my own role within education and better address the needs of clinicians undertaking the transition to practice programme; and, of primary importance, wondering how we can influence and improve the services that consumers of mental health services receive as a result of better understanding the experiences of clinicians working in this area.

Developing an understanding of qualitative research and being educated about these methodologies within my own postgraduate study led me to decide a qualitative approach was well suited to the focus of this inquiry. It is fundamental to interpretive description methodology that the research begins with a disciplinary relevant question which seeks to

generate knowledge for clinical practice (Hunt, 2009; Thorne, 2008; Thorne, Reimer Kirkham, & MacDonald-Emes, 1997). That is where this research project began.

Based on my experience, I assumed novices would find the transition to clinical practice challenging and confronting as the enormity of the reality of working in mental health and addiction is revealed. Supporting clinicians through this initial period of practice to retain practitioners in the mental health workforce is a priority for the mental health sector—one that has become more essential given the increased acuity of consumers and demands now being made of practitioners, particularly those practicing in specialist mental health services. This is an area that we can influence in our roles in education. From my perspective, I remember being shown the content of a mental health transition to programme as a potential mentor many years ago and wished that such a programme had existed when I started out in clinical practice. I could see the benefit and value of the content and, again, have assumed that others hold these same views. But perhaps this is not the case?

Engaging in this journey of learning and professional development has raised several questions for my contemplation. What do novice allied health practitioners need in the current climate of mental health care delivery? Given I last practiced clinically almost a decade ago, my own understanding of the clinical practice reality may have been outdated and irrelevant. Therefore, it seemed important to ask, is there something more we can be doing? What can we be doing differently? How can we advance our educational practices to keep up with the changing needs of consumers and clinicians; yet still be future focused to meet the needs and demands of tomorrow's mental health services? These questions merit exploration. In understanding novice practitioners' experience of the transition to practice programme, I hoped to generate insights to take back to the realms of education and clinical practice, with the intent of better equipping and supporting novices as they embark on their professional journeys in mental health and addiction. It is hoped this study may go some way to providing the answers to my questions and be a starting point for meaningful change in future transition programme practices and my own professional journey.

Potential Contribution of this Research

It was anticipated that findings from this study would reveal the experiences of practitioners undertaking transition programmes, progress mental health and addiction sector knowledge, and potentially offer direction or provoke thought as to ways to augment current allied health transition programme practices in Aotearoa New Zealand. From a workplace perspective, it was anticipated that exploring qualitative insights would complement annual feedback collected from participants of Te Pou o te Whakaaro workforce development programmes,

which, until recently, have primarily been collected through quantitative questionnaires. This study is important for advancing knowledge in this area and has value for key stakeholders within the mental health sector (i.e., employers, educators, transition programme providers) to be increasingly responsive to the needs of novice allied health practitioners undertaking specialist transition to practice programmes in Aotearoa New Zealand.

Thesis Structure

This thesis is presented in five chapters. Chapter One has provided an overview of the research context, the aims of the research, and the research question. It has included the rationale for the study based on the importance of transition programmes as an initiative for building the capacity of the workforce to be able to respond to the changing needs of consumers accessing mental health and addiction services. Insights into my position as the researcher and the reason for the project were provided.

Chapter Two presents a review of the literature to position and ground the research study within the existing professional and clinical knowledge base. The search strategy and results are presented in conjunction with a summary of the articles accessed to inform the review. The transition to clinical practice of novice allied health practitioners and the benefits and challenges faced by novice practitioners undertaking transition programmes are explored through a qualitative examination of the literature. Gaps in the literature are highlighted and the need for this research is justified.

Chapter Three provides a theoretical overview and critique of interpretive description as the methodology underpinning this research. The justification for choosing interpretive description to address the research question and the study aims is presented. Research methods of data collection and analysis are described, including the application of Braun and Clarke's (2006) six-step framework of thematic analysis. Participant recruitment, ethical considerations, and steps taken to ensure rigour throughout the research process are detailed.

Chapter Four presents the findings from the study. Consistent with thematic analysis, the findings are presented as three inter-related themes that were constructed during the data analysis process. These themes captured participants' insights and perspectives drawn from their experience of completing an allied health mental health and addiction transition to practice programme which included a postgraduate qualification.

Chapter Five concludes the thesis and situates key findings reached in relation to existing literature. Implications for practice, education, and areas for future research are considered and integrated within the discussion of the findings. Strengths and limitations of the research are critiqued, and the thesis is closed.

Chapter Two: Literature Review

This chapter synthesises and critiques the existing literature informing the study. The key purpose of reviewing the literature was to position and ground the study within the existing professional and clinical knowledge base, consistent with the interpretive description methodology guiding the research process (Thorne, 2008). The literature review provided the initial 'scaffold' for the research, influencing the focus of the research question and subsequent design, and early analysis processes of the study, again consistent with Thorne's (2008, 2016) recommendations. This chapter is structured in four sections. Section one details the literature search strategy, results, and summarises key characteristics of the studies retrieved for review. Section two presents background context to the study and considers conceptual understandings of novice allied health transitions alongside common transition challenges identified in the literature for novice allied health practitioners. Section three provides a thematic critique of novice allied health practitioners' experiences of undertaking transition to programmes and summarises key findings from the qualitative literature retrieved. Section four highlights knowledge gaps within the literature as justification of the need for this research and closes the chapter.

Section One: Literature Search Strategy

In keeping with the methodology, which encourages a broad approach to undertaking search strategies to add to resources that are easily accessed electronically (Thorne 2008, 2016), a comprehensive search of the literature was conducted. Search terms and strategies were developed with guidance from an experienced health and social sciences librarian who conducted a corresponding database search. This 'dual search process' reinforced the robustness of the search strategy and provided a 'checking' function for identifying additional literature for the review. Alongside a systematic database search, intuitive search strategies were employed, including manual reference list searches and citation searches. Utilising a range of strategies and sources ensured familiarity with the area of inquiry and enabled the identification of relevant themes and patterns in the literature, as detailed in this review.

Search Terms

Key concepts searched were 'allied health', 'novice', 'mental health', and 'transition programme'. In accordance with Thorne (2008, 2016), search terms were deliberately kept broad after initial scoping identified a paucity of research regarding allied health transition programmes within the mental health and addiction context. Due to transition programmes and novice practitioners being referred to in multiple ways, search strategies were extended to terms used interchangeably in the literature (see Appendix C for a list of extended search

terms). Additional initial inclusion criteria for the review included qualitative research published in English from peer reviewed publications and academic journals. The publication dates for identifying research covered an extended period from 2000 to 2020 due to initial search parameters of the last 10 years revealing sparse published literature. Moreover, as seminal articles referred to within accessed literature had been published prior to the initial parameters set, search parameters were extended to capture this timeframe and any additional literature relevant to the study. Nursing transition programme research has deliberately been excluded from the review due to the explicit intent of this research to focus on the allied health disciplines.

Search Results

Four databases (CINAHL, PsycINFO, PubMED, SCOPUS) were searched due to their inclusion of occupational therapy, social work, and allied health research. The initial systematic search resulted in 537 studies being identified. After reviewing titles, abstracts, and removing duplicates, 511 articles were excluded. Full text articles were sought for the remaining 26 studies, one of which was not able to be retrieved. After reviewing the 25 articles, 18 were removed due to being irrelevant to the research topic (e.g., focusing solely on describing transition to practice and/or from nursing or midwifery disciplines exclusively). Articles with purely quantitative methodologies were excluded as these were deemed unlikely to fully capture the subjective experiences of novice practitioners engaging in transition to practice programmes. Research pertaining to undergraduates or new graduate nursing transition programmes was not included due to these studies excluding the experience of graduate allied health practitioners.

Reference list and intuitive searches provided two additional sources that met inclusion criteria, and two evaluations of transition programmes that collated qualitative feedback from novice allied health practitioners completing transition programmes were accessed from Te Pou o te Whakaaro Nui's website. This resulted in a total of 11 studies being included in the review of the literature (see Appendix D for flow diagram of search strategy and results). This explanation of the search strategy provides important insights into the available published literature regarding novice allied health transition programme experiences, specifically within the mental health and addictions context.

Critique of the Research Literature

The Critical Appraisal Skills Programme (CASP) (2018) checklist was used to analyse the quality of research articles selected; and consider the validity of study results, research design, and the value and applicability of results to the current study. This tool is recommended for the

critique of qualitative studies and was devised for use within health and sciences research (Long, French, & Brooks, 2020). Overall, appraisal of accessed articles was considered to range from low to medium quality. However, because of the limited literature available, it was decided that studies would not be excluded from the review based on quality. All of the research articles from the literature search had a qualitative methodology component exploring the experiences of allied health participants completing transition programmes as part of the study design. This enabled an overview of available qualitative research evidence so that the findings from this study can be considered in relation to the current context.

As mentioned, 11 articles were selected and included within this review (see Appendix E for summary table of articles accessed). There were no integrative reviews of allied health transition programmes located within the literature search, suggesting that at present there is limited research available in this area to allow such an inquiry. There was also a paucity of research pertaining to mental health and addiction transition to practice programmes, allied health transition programmes, or research from the Aotearoa New Zealand context. It is also important to note, there was significant variation across the literature retrieved as to transition programme components, the study designs and methods evaluating participants experiences of transition programmes, and the clinical practice areas that have been explored to date.

Thorne (2016) asserted that the key requirements of a literature review within interpretive description studies is to identify what is already known about a topic and how that knowledge has been generated. As such, a rigorous analysis of the research included in the review was compiled as part of critiquing existing literature informing the study (see Appendix F for narrative overview of research included in the review). This was a lengthy and considered process that was undertaken over a three month period. The analysis included examining the contexts that the current research had emerged from; how transition programmes had been researched previously (e.g. methodological approaches and research methods employed); the participant perspectives that have been captured within the research and those that had not; and the clinical practice areas that research had predominantly been conducted within. This analysis supported the identification of gaps in the existing research that this study could meaningfully contribute to addressing. These knowledge gaps are detailed in section four of this chapter and further support justification of the need for this research.

Furthermore, Thorne (2016) advised that the aims and objectives of a literature review also needed to support explanation of the current knowledge base about a topic. As such, this review examined the literature regarding allied health novices transition to practice, and transition programme experiences, in relation to the following questions:

(a) What are key conceptualisations underpinning allied health novices transition to practice?
(b) How do allied health novices describe their experiences of the transition to practice?
(c) What are the commonalities of allied health novices experiences of transition to practice programmes?
(d) How does engaging in a transition to practice programme influence allied health novices transition to practice?

In the context of the research question, the themes that emerged from the critical review of the literature were determined by reading and review of the selected articles numerous times to develop knowledge and deepen understanding of the topic. Articles were initially coded in relation to conceptual and theoretical models of novices transition to practice, novices experiences of the transition to practice identified in the findings and commonalities in the literature regarding novices experiences of transition programmes. Further analysis involved collating initial codes and identifying patterns in novices descriptions of their transition programme experiences and how the programmes influenced the transition, from the research included in the review. Findings were then grouped into themes, and subthemes, which focused on facilitators and barriers to transition reported within the literature. As such the literature review is structured in accordance with themes identified from the review and critique of the literature.

Section Two: Background Context

Section two examines conceptual understandings of novice allied health transition and synthesises common challenges that novice allied health practitioners encounter during the transition. Given transition programmes have evolved from the recognition of the need to better support novice practitioners' successful transition, gaining an understanding of challenges novices encounter during transition is relevant to the research focus.

Conceptual Understandings of Novices Transition to Practice

Early research into novice transitions was conducted within nursing by Kramer (1974) who identified the phenomena of *reality shock* new graduates experienced during the transition to clinical practice. This was characterised by negative feelings about the profession following a realisation that expectations of nurses' roles were inconsistent with the reality of clinical practice (Kramer, 1974). Novices experiencing *reality shock* led to feelings of internal conflict and decreased job satisfaction during transition, and was recognised to be a time of

vulnerability when novices were at risk of burnout or leaving their respective professions (Glassburn, 2020). The concept of *reality shock* has relevance for wider professional practice today. Modern models and explorations of the transition to practice identify similar phenomena experienced by novice practitioners within the present-day healthcare context (Duchscher, 2009; Murray, Sundin, & Cope, 2019). Building on Kramer's original work, conceptual and theoretical models of the transition to practice have been developed that capture the transition experiences of novice allied health practitioners (Glassburn, 2020; Tryssenaar & Perkins, 2001).

Tryssenaar and Perkins (2001) are widely cited for their small-scale phenomenological exploration of the lived experience of the transition to clinical practice of six rehabilitation students (Quick et al., 2007; Smith & Pilling, 2007, 2008; Toal-Sullivan, 2006). Three occupational therapy and three physiotherapy students compiled reflective journals from their final student placement through to finishing their first year of clinical practice (Tryssenaar & Perkins, 2001). In addition to common themes reported during the transition, analysis of participant journals identified four sequential stages participants journeyed through during the transition period—'transition', 'euphoria and angst', 'reality of practice', and, finally, 'adaptation to practice' (Tryssenaar & Perkins, 2001). Although a limitation of this study was having no male or mature students as participants, understanding the sequential developmental phases allied health graduates progress through during transition was deemed essential knowledge for practitioners supporting novices during transition. Tryssenaar and Perkins argued this would ensure interventions provided matched the support needs of novice practitioners at each transitional stage and contribute to reducing novice anxieties and transition challenges.

Like Tryssenaar and Perkins (2001), Glassburn (2020) concluded there were 'critical points' where new graduates needed additional support and encouragement during the transition to practice. Their grounded theory study used semi-structured interviews to explore the transition from student to health practitioner for 27 Masters of Social Work graduates in the United States. Glassburn assessed novice practitioners' progress through a five-stage process during the transition to practice that had similar conceptual understandings to those reported by Tryssenaar and Perkins. However, Glassburn further proposed novice practitioners also require additional preparation for practice during undergraduate training; an extended orientation period to the workplace; a dedicated supervisor or mentor; and education about compassion fatigue, self-care, and wellbeing during the first year of practice.

A lack of diversity in participants recruited to Glassburn's (2020) study suggested findings may not be representative of the wider novice allied health population; however, the consensus of

both preceding studies is that understanding the transition period and stages that novice practitioners progress through during the transition to practice has value for both undergraduate and postgraduate education providers and organisations employing novice practitioners (Glassburn, 2020; Tryssenaar & Perkins, 2001). Furthermore, it is contended that there is value for novice practitioners deepening understanding of the transition process themselves, in order to expedite their own successful transition to practice (Glassburn, 2020; Tryssenaar & Perkins, 2001).

Common Challenges Experienced by Novices Transitioning to Practice

Feeling Unprepared for Practice

Preparing graduates capable of entering the professional workforce is an important function of undergraduate professional programmes; however, the literature reviewed illustrated graduates often report feeling unprepared for practice within both social work and occupational therapy disciplines (Hunt et al., 2016; Robertson & Griffiths, 2009). Beddoe, Hay, Maidment, Ballantyne, and Walker (2018), in their study of social workers' readiness for practice, stated the challenge of novice preparedness for practice has increased as the social work profession has evolved, and clinical practice has become more demanding. Gray et al. (2012) conducted a between-country comparison into the differences in perceived preparedness for practice of occupational therapy graduates from Aotearoa New Zealand and Australia. They concluded most new graduates felt 'somewhat prepared' for practice; yet, also identified only 17.1% of Australian new graduates, and 8.5% of Aotearoa New Zealand new graduates, felt 'very well prepared' for practice (Gray et al., 2012). Similarly, Glassburn's (2020) more recent grounded theory exploration of Master of Social Work graduate transitions revealed social workers felt underprepared for clinical practice by their undergraduate training; showing the tension of preparedness for practice remains a concern for novice practitioners today.

Early research conducted by Adamson, Hunt, Harris, and Hummel (1998) examined how well undergraduate programmes had prepared 144 Australian occupational therapy graduates for professional practice by comparing the skills graduates described needing for practice against those acquired during undergraduate training. They discerned several key areas in which novice practitioners considered their training had been lacking, including not acquiring skills to communicate with other disciplines or the general public, limited understanding of the wider health context, and not developing skills for managing stress or coping with the clinical practice environment (Adamson et al., 1998). Many studies report novice practitioners felt inadequately prepared in terms of communication skills; further differentiating that novice

practitioners required technical knowledge and skills (Doherty, Stagnetti, & Schoo, 2009; Hunt et al., 2016; Moriarty et al., 2011; Toal-Sullivan, 2006), practical assessment and intervention abilities (Hodgetts et al., 2007; Robertson & Griffiths, 2009), and experience applying evidence in practice (Gray et al., 2012; Robertson & Griffiths, 2009) to enhance practitioner preparedness.

Lastly, Lloyd et al. (2007) explored the challenges that 15 new graduate Australian occupational therapists faced during the transition to mental health practice. They determined graduates felt unprepared for mental health practice in relation to mental health assessments and interventions (i.e., medication, diagnosis, cognitive and dialectic therapies); mental health legislation; managing the stress of being responsible for consumers; and advancing their professional identity when practicing in generic mental health roles such as case managers or keyworkers (Lloyd et al., 2007). Lloyd et al. concluded that undergraduate programmes must better prepare students for contemporary practice, particularly in the specialist area of mental health and addiction.

Lacking Confidence and Competence

Closely linked to novice allied health practitioner preparedness for practice in the literature were the concepts of confidence and competence. It has been established that it takes at least one year for novice allied health practitioners to transition to practice and feel professionally competent (Casey, Fink, Krugman, & Propst, 2004; Lee & Mackenzie, 2003; Seah et al., 2011; Tryssenaar & Perkins, 2007; Quick et al., 2007). Thus, it is perhaps unsurprising that novice practitioners describe initially lacking confidence and competence in professional skills and practical abilities during the transition year (Gray et al., 2012; Moorhead, 2019; Moriarty et al., 2011; Morley, Rugg, & Drew, 2007; Robertson & Griffiths, 2009). As Gray et al. (2012) posited, this points to a need for ongoing research exploring strategies for increasing practitioner competence and facilitating novice practitioners' successful transition.

Master of Occupational Therapy participants in Seah et al.'s (2011) research described feeling they were "thrown in the deep end" (p. 107) when entering clinical practice and had to "sink or swim" (p. 107) which was impeded by lacking confidence in their clinical skills. Moreover, not feeling confident they were doing a "good enough job" (p. 150) was identified by Glassburn (2020) as negatively influencing the transition from student to health professional for social work practitioners. Novice practitioner confidence was further undermined upon recognising the need to acquire additional context-specific knowledge to manage the demands of practice expectations when entering the workforce (Gray et al., 2012; Murray et al., 2019; Sutton & Griffin, 2000; Toal-Sullivan, 2006). Because of lack of confidence, novices doubted

their clinical reasoning abilities (Doherty et al., 2009), feared making mistakes or taking responsibility for clinical decision making when first starting employment (Lee & Mackenzie, 2003). Moreover, Nayar, Gray, and Blijlevens (2013) found novices lacked confidence in their ability to deliver safe practice during transition, particularly in areas like identifying and managing risk within mental health and addiction practice.

Managing Expectations

Changing status from student to health practitioner is accompanied by changes in expectations; both expectations placed on novice practitioners by others and expectations novices placed upon themselves. Expectations significantly influenced how novice practitioners experienced the transition to practice (Morley, 2009a). Several studies found novice practitioners experienced greater levels of stress and anxiety than anticipated when entering clinical practice (Glassburn, 2020; Seah et al., 2011; Tryssenaar & Perkins, 2001). Novice practitioners in Seah et al.'s (2011) study placed expectations upon themselves to prove to colleagues that they were now practitioners as opposed to students. Yet, these expectations were further complicated by participants feeling uncertain as novices, and having little understanding of workplace practice requirements (Seah et al., 2011). Conversely, when novices' workplace expectations felt unachievable, such as having high or complex caseloads beyond their capabilities, novice felt pressured, took a break from practice (Glassburn, 2020), or had to complete tasks outside of work hours to meet their clinical responsibilities (Toal-Sullivan, 2001).

Sutton and Griffin's (2000) nation-wide study exploring the practice expectations of 295 occupational therapy graduates in Australia found that new graduates often held 'inflated expectations' when starting their first clinical role and perceived they would be valued in their new roles by colleagues and service users. Novice practitioners expected to feel competent in their skills and abilities and had high expectations of what clinical practice would entail (Glassburn 2020; Sutton & Griffin, 2000). Participants described expecting access to quality supervision; to have positive interactions with colleagues; that their work would be challenging, but enjoyable; and that they would make a difference in their clients lives (Sutton & Griffin, 2000). However, novices detailed experiencing unexpected challenges translating undergraduate knowledge to practice in addition to struggling with taking on increased responsibility and client care (Sutton & Griffin, 2000). Hence, the reality of clinical practice can be experienced as significantly different to what novice practitioners anticipate (Beddoe et al., 2018; Glassburn, 2020; Toal-Sullivan, 2006; Tryssenaar & Perkins, 2001).

Finally, experiencing reality shock has been linked to graduates having decreased job satisfaction, feeling unprepared for full time work and the accompanying responsibilities while struggling to navigate an unfamiliar work environment during transition (Hunt et al., 2016; Melman et al., 2016; Moorhead, 2019). Having unmet expectations during transition has also been shown to negatively impact the retention of therapists within the allied health professions (Lee & Mackenzie, 2003; Lloyd et al., 2007). Thus, the need for further research directed towards understanding the role unrealistic expectations play in job satisfaction and withdrawal of novice practitioners from practice has been raised.

Lack of Orientation and Supervision

Having poor quality inductions or orientations to the workplace were found to impede the successful transition to practice for allied health practitioners (Glassburn, 2020; Hunt et al., 2016; Moriarty et al., 2011). Social work transition research recognised the need to extend orientation periods of novices due to usual orientation periods being insufficient for novices to effectively assimilate to the workplace (Glassburn, 2020; Hunt et al., 2016). Quick et al. (2007) identified that the level of support novice practitioners received when entering practice correlated directly to the level of transition stress novices reported experiencing; a factor closely linked to novice attrition in the literature (Beddoe et al., 2018; Lee & Mackenzie, 2003; Lloyd et al., 2007). Furthermore, having little professional support combined with high and complex caseloads during orientation and transition were identified as challenging for novice practitioners due to not yet having the knowledge or professional capabilities to manage clinical demands like their more experienced colleagues (Glassburn, 2020; Hunt et al., 2016; Moorhead, 2019).

Providing supervision is a common practice within the healthcare sector intended to progress novice practitioner competence and confidence (Beddoe et al., 2018; Melman et al., 2016). Despite recognition of its importance, novice practitioners frequently report having inadequate supervision or support to manage the stress of transition and adapting to clinical practice (Beddoe et al., 2018; Melman et al., 2016; Moorhead, 2019). Factors negatively influencing novice practitioners' experiences of supervision included feeling intimidated by supervisors, not seeking out supervisor support (Sweeney, Webley, & Treacher, 2001), or feeling they had to prove their competence to their supervisors (Morrison & Robertson, 2015). Moreover, Gray et al. (2012) discovered only one third of Australian or Aotearoa New Zealand occupational therapy graduates felt confident in their abilities to utilise supervision effectively as novices. These findings may go some way to explaining why novice social workers in Glassburn's (2020) research described supervision as being "hit or miss" (p. 149); novices may

not fully understand the purpose of supervision or have anxieties about being judged that interfere with fully engaging in the supervision process during the transition to practice.

Several small-scale studies exploring novice practitioners' experiences of supervision identified significant challenges related to the quality and quantity of supervision novices received (Glassburn, 2020; Melman et al., 2016; Morley et al., 2007). Insufficient supervision or limited guidance were found to negatively impact the transition and professional development of novice allied health practitioners (Lee & Mackenzie, 2003; Moriarty et al., 2011; Robertson & Griffiths, 2009). Research exploring supervision from the perspective of occupational therapy students and recent graduates in Australia and Aotearoa New Zealand found a small percentage of novices did not receive supervision at all during transition (Melman et al., 2016). Having infrequent or irregular supervision was identified as challenging for novice practitioners by Lee and Mackenzie (2003) and Morley et al. (2007) who deemed lack of supervisory support was a more prevalent concern for novices in sole positions or isolated roles such as those in rural practice. Lack of supervision may be due to novice practitioners not having access to supervision during the critical transition period, or being unaware of how to best utilise this practice when entering the workforce. This is concerning as it precludes novices from gaining support essential to translating undergraduate training to practice, reducing transition stress, identifying ongoing learning needs, or observing role models in practice (Glassburn, 2020; Melman et al., 2016; Moores & Fitzgerald, 2017).

In the absence of supervision, novice practitioners sought support and feedback from more experienced colleagues in the workplace. However, the danger of not having support from colleagues of the same profession was recognised by supervisors in Morley's (2009b) research evaluating contextual factors impacting novice transitions. They reported an occupational therapy graduate supported during transition by a physiotherapist took on the language and identity of physiotherapy as opposed to that of their own discipline (Morley, 2009b). This finding was supported by Robertson and Griffiths (2009) and Moorhead (2019) who proposed limited opportunities for reflection on clinical experiences within professional supervision was a barrier to novices building a discipline specific identity, particularly during early stages of transition.

Establishing Professional Identity

Developing and establishing professional identity was identified as a final challenge for novice practitioners during transition (Moores & Fitzgerald, 2017; Moorhead, 2019). Not constructing a clear professional identity during transition led to novices doubting themselves, having negative transition experiences, and lacking confidence in clinical practice abilities (Lee &

Mackenzie, 2003; Robertson & Griffiths, 2009; Tryssenaar & Perkins, 2001). Novices described initially finding it difficult to assume their new identity of healthcare professionals, needing to adjust from thinking of themselves as students (Lee & Mackenzie, 2003; Seah et al., 2011). They also required time to settle into their identities as employees and professionals (Moorhead, 2019). A paradoxical challenge identified for novice occupational therapists by Robertson and Griffiths (2009) was articulating their professional role to others (e.g., consumers/colleagues) when holding little understanding of this themselves.

Building professional identity during transition was impeded by a perceived lack of role clarity (Acker, 2004; Parker, 1991) and role blurring (Morley et al., 2007); factors compounded by novices not having discipline specific role models available in the workplace (Moores & Fitzgerald, 2017; Morrison & Robertson, 2015). Occupational therapists and social workers often work autonomously, or as lone professionals within multi-disciplinary teams, which can create role confusion for novices (Lloyd et al., 2007; Robertson & Griffiths, 2009). Moreover, role confusion has been recognised as a pressing challenge for novice practitioners transitioning to mental health services who are employed more and more in generic keyworker roles (Lloyd et al., 2007).

Occupying generic roles or carrying out generic tasks can negatively impact novices building a distinct professional identity due to having few opportunities to apply and advance their discipline specific professional skills (Lloyd, King, & Bassett, 2002; Lloyd, King, & McKenna, 2004; Moorhead, 2019). Novices may also be expected to provide interventions, assessments, or complete tasks that were not taught during their undergraduate training (Lloyd et al., 2007). Novices, therefore, may miss opportunities to develop expertise enacting core tasks of their professions that would consolidate professional identity during transition, especially those practicing in mental health and addiction services (Lloyd, King, & McKenna, 2004; Lloyd et al., 2007).

In summary, the context information presented in this section has shown that the transition to practice for novice allied health practitioners is complex, stressful, and influenced by several contextual factors. Novices experienced challenges in transition related to feeling unprepared for practice; lacking confidence and competence; having unmet expectations; insufficient supervision or orientation; and developing their professional identity. Furthermore, there are clearly identified stages of development that novice allied health practitioners progress through during the transition from undergraduate to health practitioners (Glassburn, 2020; Tryssenaar & Perkins, 2001). Supporting novice practitioners through these stages to assimilate and successfully integrate into professional practice are important considerations

for the allied health disciplines as they seek to retain relevance in the ever-changing context of modern healthcare and service delivery.

Robertson and Griffiths (2009) described new graduates as the "lifeblood of the profession" (p. 126) and discussed the need to adequately equip graduates to practice and survive in contemporary healthcare practice. Transition programmes that address the challenges novices encounter during transition and support a successful introduction to clinical practice are an important strategy adopted within the allied health professions to achieve this (Pack, 2010; Smith & Jury, 2017; Te Pou o te Whakaaro Nui, n.d.). While it is important to understand the transition process and common challenges of transition, this does not provide insights into the experiences of novice practitioners participating in transition programmes as it cannot be assumed that they will have a corresponding experience of transition. As such, studies identified from the literature search that explore the experiences of novice allied health practitioners completing transition programmes are synthesised and presented in the following section.

Section Three: Novice Allied Health Transition Programme Experiences

Given the focus of this study on novice allied health practitioners, this section provides an overview of the commonalities of novices' experiences of transition programmes, and explores benefits novices gained alongside challenges and difficulties they faced, as described in the literature.

Several benefits were identified in the literature in relation to participants' experiences of transition to practice programmes. These included increasing novice confidence and competence; peer support; professional support from preceptors, supervisors, and colleagues; and funding and financial incentives. Additionally, organisational benefits of transition programmes were identified which included the positive impact transition programmes made to novice practitioner recruitment and retention.

Increased Confidence and Competence

Consistent across the literature was the finding that development of confidence and competence were significant benefits novice participants gained from participating in transition programmes, irrespective of the formal or informal nature of the transition programme (Banks et al., 2011; Liddiard et al., 2017; Morley 2009a; Smith & Pilling, 2007; Te Pou o te Whakaaro Nui, 2017b). Novice practitioners in Smith and Pilling's (2007) pilot study evaluation reported feeling more competent and confident after 5-6 months of engaging in the transition programme. Participants identified specific aspects of the programme that enhanced novice competence and confidence in their roles, which included building

relationships with other professionals, discussing worries within a supportive environment, and having a greater appreciation of wider services and organisations they were working within (Smith & Pilling, 2007).

Similarly, Banks et al. (2011) found that practitioner confidence and competence were enhanced by the learning and skill development gained from completing structured transition programme educational tasks and activities. Completing online modules, directed towards building clinical skill, knowledge, and safe and reflective practice, was one of the most beneficial elements of transition programmes for novice practitioners (Banks et al., 2011). Te Pou o te Whakaaro Nui's (2018a) student survey also found novice practitioners gained clinical confidence from acquiring knowledge as a direct result of the training provided within transition programmes. They identified technical skills such as talking therapies, motivational interviewing, and diagnostic and assessment skills as key areas of knowledge acquisition transition programmes that supported increasing practitioner confidence and competence (Te Pou o te Whakaaro Nui, 2018a).

Furthermore, novice practitioners described acquiring expanded understandings of mental health and professional practice through developing reflective practice skills, and learning about the importance of empathy, approaches to practice like recovery or trauma informed care (Te Pou o te Whakaaro Nui, 2018a). Feeling competent and confident was enhanced for novice allied health practitioners through applying transition programme knowledge in practice, teaching these skills to others, or sharing this knowledge with colleagues (Solowiej, Upton, & Upton, 2010; Te Pou o te Whakaaro Nui, 2018a). Growing the confidence and competence of novice practitioners was also identified as contributing to the career progression and advancement of novice practitioners within their respective professions (Solowiej et al., 2010).

Specific to the mental health and addiction context, novice practitioners reported gaining a deeper understanding of mental health practice, like evidence-based practice, best practice guidelines and policies, and applying these in practice which contributed to developing practitioner confidence (Te Pou o te Whakaaro Nui, 2018a). Novice practitioners completing Te Pou o te Whakaaro Nui's (2017b) transition programmes described having increased confidence in their clinical practice abilities for working with family/whānau through acquiring skills that enabled them to work more effectively with consumers, particularly those who identified as Māori. This is significant given Aotearoa New Zealand's bicultural healthcare context. Feeling more confident and able to practice safely because of the training offered within transition programmes also facilitated novice practitioners to feel more confident to work with consumers who had co-existing mental health and addiction concerns (Te Pou o te

Whakaaro Nui, 2017b, 2018a); thus, highlighting the importance of providing context specific technical knowledge and training within transition programme content.

Peer Support

The majority of studies cited peer support as one of the most beneficial elements novice practitioners gained from transition to practice programmes, with only two studies not specifically discussing this within their evaluations (Fitzgerald et al., 2015; Te Pou o te Whakaaro Nui, 2017b). Novice practitioners valued having opportunities to build relationships and spend time with peers who were at a similar transitional stage and professional development as themselves (Erol, Upton, & Upton, 2016; Liddiard et al., 2017; Morley, 2009b). Developing peer connections within transition programmes facilitated novices sharing transition concerns, and encouraged debriefing about practice and discussing challenges as they arose (Erol et al., 2016; Liddiard et al., 2017; Smith & Pilling, 2008), which provided reassurance that peers were experiencing similar anxieties and issues (Morley, 2009a; Smith & Pilling, 2008). For some novice practitioners, building informal peer relationships decreased their sense of isolation during the transition, which was particularly valuable for those in sole practitioner positions (Morley, 2009a; Smith & Pilling, 2008). Networking with novice practitioners from other service areas, that would not normally be possible within usual induction or orientation processes, was also highly valued (Smith & Pilling, 2007, 2008).

Peer support was created within transition programmes by novices sharing stories, hearing other novice practitioners' experiences, building trust, and recognising that feeling inadequate was a common experience during the transition to practice (Liddiard et al., 2017; Smith & Pilling, 2007). Meeting with peers within the context of transition programmes allowed novice practitioners opportunities to process their feelings regarding transition and created a safe environment to ask questions (Liddiard et al., 2017; Smith & Pilling, 2008). Engaging in reflective problem-solving practices within peer support forums also contributed to novice practitioners feeling they were supporting others during the transition to practice (Liddiard et al., 2017; Te Pou o te Whakaaro Nui, 2018a). Furthermore, peer support built within transition programmes was identified as an important factor for maintaining motivation and engagement during the transition year and supported novice practitioners to successfully complete transition programmes (Erol et al., 2016; Te Pou o te Whakaaro Nui, 2017b, 2018a).

Peer support was actively facilitated within most transition programmes or formed a core part of the purpose of the programme (Liddiard et al., 2017; Smith & Pilling, 2007). In predominantly web-based transition programmes, such as the Flying Start initiatives in Scotland, participants were encouraged to independently engage in peer support groups or to

access online communities and new graduate discussion forums (Banks et al., 2011). These studies found peer support that took place face-to-face within transition programmes was more highly valued and had a greater impact than peer support facilitated within online platforms (Banks et al., 2011; Solowiej et al., 2010). According to Banks et al. (2011), online forums were accessed less and viewed as less supportive compared to face-to-face peer support, providing important insights into structuring and implementing effective peer support practices within transition programmes.

Preceptorship and Supportive Practices

In addition to peer support other supportive practices novice practitioners valued within transition to practice programmes were the provision of preceptorship (Banks et al., 2011; Erol et al., 2016; Morley, 2009a, 2009b; Te Pou o te Whakaaro Nui, 2017b; 2018a) and formal supervision and guidance (Fitzgerald et al., 2015; Morley, 2009a, 2009b). Morley (2009a) defined preceptorship as,

> a structured development process, including observed practice and feedback against agreed standards, to support newly qualified practitioners to build their professional identity and competence in order to facilitate their successful adaptation into the workplace. (p. 388)

When the above elements were present within preceptorship, it was viewed as more supportive and beneficial (Morley 2009a, 2009b). Solowiej et al.'s (2010) evaluation of an allied health transition programme pilot found that the majority of participants viewed preceptorship positively and as supportive, with only a small percentage (5.8%) describing it as "not at all supportive" (p. 498). Overall, the preceptorship practices valued most by novice practitioners were receiving feedback on their performance in practice, gaining reassurance to progress clinical skills, and support to cope with the emotional aspects of practice during transition (Morley, 2009a).

When novice practitioners were observed in practice by preceptors and they reflected on this experience together afterwards, it encouraged engaging in reflective practice so novices could learn from their experiences (Morley, 2009a). Receiving feedback from preceptors on clinical performance increased novices' self-awareness, knowledge acquisition, and professional development (Morley, 2009a, 2009b). Despite observation being anxiety provoking and lead to some novice practitioners feeling judged, this practice was viewed as a significant benefit of preceptorship (Morley, 2009a). Additionally, observing preceptors in practice was a component of transition programme preceptorship highly valued by novice practitioners, as it provided role-modelling and enhanced novices' understanding of their own disciplinary roles and wider allied health practice priorities (Morley, 2009a, 2009b).

Fitzgerald et al. (2015) identified the foundational role preceptors played in understanding the challenges of transition to practice and encouraging novice practitioners to engage positively in learning tasks. Preceptorship was most successful when novice practitioners were invested and actively participated in the learning process, when a supportive learning environment was created, and a culture existed where the novice practitioner could discuss their learning needs honestly (Fitzgerald et al., 2015). Sharing their vulnerabilities and not having to present as confident and competent led to the most positive outcomes of preceptorship for novice practitioners within the context of transition to practice programmes (Morley, 2009b). Morley (2009b) also identified that preceptorship, like peer support, encouraged novice practitioners to remain motivated and engaged in transition programmes.

Alongside preceptorship, formal supervision was a valued avenue of support for novice practitioners completing transition to practice programmes (Fitzgerald et al., 2015; Morley, 2009a). Supervision and learning activities that were structured and planned in advance were valued more than unstructured learning opportunities (Morley, 2009a). Although not specific to transition programmes, informal support and learning from experienced colleagues, especially those from the same profession, were important factors identified as effective in supporting novice practitioners during the transition to practice. Such practices were even more essential if preceptors were unavailable (Morley, 2009a, 2009b). Therefore, colleagues understanding transition programme requirements becomes vital in the absence of access to preceptors and strengthens the need for all team members to be conversant with transition programme components to provide timely and appropriate support for novices in the workplace.

Funding and Financial Incentives

Five of the transition programmes in the literature reviewed were linked to funding, maintaining employment, or were financially incentivised (Banks et al., 2011; Erol et al., 2016; Morley 2009a, 2009b; Solowiej et al., 2010; Te Pou o te Whakaaro Nui, 2017b, 2018a). Some studies detailed funding practitioners transition programme fees, contributing to travel, and incidental transition programme costs (Te Pou o te Whakaaro Nui, 2017b, 2018a); while others stipulated successful completion of the programme was a condition of novices' employment (Banks et al., 2011). All five programmes reported positive benefits from funding or financial incentives being linked to novice transition programme completion (Banks et al., 2011; Erol et al., 2016; Morley 2009a, 2009b; Solowiej et al., 2010; Te Pou o te Whakaaro Nui, 2017b, 2018a). Furthermore, novices reported being grateful for the funding and the subsequent access to professional development, while describing being more likely to participate in the

transition programmes because of the funding provided (Te Pou o te Whakaaro Nui, 2017b, 2018a).

Offering financial support was a foundational component of a two year transition programme in Scotland that offered novice practitioners annual funding based on successful completion of the programme (Solowiej et al., 2010). Novice practitioners could use these payments to assist with personal costs (e.g., daily living, housing, rent, student loans etc.) or continued professional development. Participants reported the funding eased the challenges of transition, with 86% of participants indicating they would recommend the scheme to other novice practitioners (Solowiej et al., 2010). Despite financial incentives being valued by novice practitioners, Solowiej et al. (2010) argued financial incentives should be embedded as only one aspect of transition programme support rather than the sole incentive for novices completing transition to practice programmes.

Morley's (2009a) small qualitative study explored the experiences of four novice occupational therapists and their preceptors undertaking a preceptorship pilot programme in the United Kingdom, where completion of transition programme activities, based on professional competencies, were linked to salary increases. Progress towards programme goals was evaluated by managers at 6 and 12 month intervals, and if achieved, pay advancements were allocated, which was found to encourage participants' continued engagement and completion of the programme (Morley, 2009a). Similarly, Erol et al. (2016) reported financial incentives in conjunction with professional promotion to a more senior rank as motivating factors for novice practitioners completing transition programmes. Increased remuneration was viewed by novice practitioners as external acknowledgement of progress towards being a competent practitioner as well as being rewarded for the professional development work undertaken (Erol et al., 2016).

Recruitment and Retention

Organisational benefits of transition to practice programmes identified across the literature were the positive contribution they made to the retention and recruitment of novice allied health practitioners. Recruitment was found to be positively affected by several key benefits transition programmes offered novices such as funding, professional development, and career progression (Erol et al., 2016; Smith & Pilling, 2007; Solowiej et al., 2010; Te Pou o te Whakaaro Nui, 2017b, 2018a). Transition programmes delivered via online platforms were identified as significantly influencing novice recruitment, as this permitted novice practitioners to live and practice anywhere they chose yet still have access to professional development and

future professional advancement (Banks et al., 2011; Erol et al., 2016; Solowiej et al., 2010; Te Pou o te Whakaaro Nui, 2018a).

Recruitment was found to be influenced by novices having positive experiences of programmes, as participants indicated they would recommend the transition programmes to other clinicians (Erol et al., 2016; Smith & Pilling, 2007; Solowiej et al., 2010; Te Pou o te Whakaaro Nui, 2017b, 2018a). Furthermore, Liddiard et al.'s (2017) informal 'job club' programme which supported novice practitioners in gaining employment and eased the transition from student to professional, was believed to reduce the risk of attrition of novice practitioners from the allied health professions during the transition period, particularly when seeking employment (Liddiard et al., 2017).

The literature revealed transition programmes played a significant role in novice practitioners' decisions to remain working for the organisations that supported their transition programme participation (Smith & Pilling, 2007, 2008; Solowiej et al., 2010; Te Pou o te Whakaaro Nui, 2017b, 2018a). Additionally, novice practitioners within Te Pou o te Whakaaro Nui's (2017b, 2018a) studies stated they intended to remain practicing within the mental health sector as a direct result of participating in transition programmes, with a significant majority indicating that they planned to do so for between 3 and 10 years.

One of the first allied health transition programmes implemented internationally discovered significant improvement in retention rates of novice practitioners for the two years following the introduction of a pilot transition to practice programme within an Australian metropolitan health service (Smith & Pilling, 2007). This finding was supported by Solowiej et al. (2010) who assessed novice retention was influenced by graduates feeling valued because of organisational support for transition programmes, alongside novices developing a greater understanding of allied health priorities within their respective workplaces. Likewise, a later transition programme evaluation conducted by Banks et al. (2011) in Scotland also recognised the role transition programmes played in supporting novice retention; further arguing the initial organisational investment made in supporting transition programmes would be repaid through increased practitioner confidence and competence and result in novices remaining longer in their clinical roles.

While the literature identified significant improvements in novice practitioner retention rates, these outcomes were presented with caution. Despite encouraging indications, it was difficult to attribute the positive change in retention or recruitment solely to the influence of transition programmes (Liddiard et al., 2017; Morley, 2009a, 2009b; Te Pou o te Whakaaro Nui, 2017b,

2018a). Further exploration of the impact of transition to practice programmes on the retention and recruitment of allied health novice practitioners would be recommended.

Challenges of Allied Health Transition Programmes

Despite the benefits outlined previously, several challenges and barriers were encountered by novice practitioners engaging in transition to practice programmes. These included a perceived lack of support from workplaces and senior management, transition programme workloads, having a lack of protected time, and limited access to preceptors.

Lack of Organisational Support

A significant challenge reported by novice practitioners occurred when transition programmes were not supported and embedded within an organisation or were not an integral part of workplace culture (Banks et al., 2011; Erol et al., 2016; Solowiej et al., 2010). Senior management and colleagues lacking knowledge of the components of transition programmes and their corresponding role devalued the transition programme and novice practitioners' role within these, which led to novices reporting little perceived benefit from participating in transition programmes (Morley 2009a; Solowiej et al., 2010). Moreover, an unsupportive learning culture within the workplace or the organisation negatively impacted novice practitioners' successful completion of transition programmes (Erol et al., 2016). This was exacerbated when there were differing perceptions of the practice requirements of novice practitioners undertaking transition programmes, and the organisations and clinicians providing transition support (Banks et al., 2011; Erol et al., 2016). This disparity can have negative consequences for novice practitioners, as Morley (2009b) and Banks et al. (2011) identified, and can result in novice practitioners' withdrawal from transition programmes altogether.

Improving organisational support was considered to be fostered by novice practitioners' managers and colleagues having a good understanding of the transition programme and supporting it at a strategic level. This was suggested to maximise the impact of the transition programme and could result in the programme being viewed as more beneficial by novice practitioners (Morley 2009b; Smith & Pilling, 2007). Strategies for demonstrating increased organisational support of transition programmes included having managers and senior staff engaged and present during transition programme activities (Smith & Pilling, 2007). This was believed to contribute to more consistent transition programme implementation, and provide evidence that management supported, understood, and valued the programme within the organisation (Smith & Pilling, 2007, 2008). Prioritising transition programmes within an organisation was demonstrated through allowing protected time for novices to complete

transition programme work, establishing organisation-wide policies facilitating programme implementation, and ensuring transition challenges and strategies to overcome these were more widely understood within clinical teams (Morley, 2009a). Furthermore Erol et al. (2016) suggested having the successful completion of the transition programme acknowledged by senior management would demonstrate the organisation's commitment and support of novice practitioners undertaking transition programmes.

Transition Programme Workloads

The literature reviewed in the section two established that novice practitioners face significant challenges during the transition to practice including adjusting to working full-time, carrying responsibility for patient care, managing demanding clinical caseloads, and feeling the complexities of these tasks were beyond their competence or expertise (Moriarty et al., 2011; Solowiej et al., 2010; Tryssenaar & Perkins, 2001). In addition to these common transition challenges, novice practitioners undertaking transition to practice programmes reported clinical caseloads and transition programme workloads were too high and unmanageable (Banks et al., 2011; Smith & Pilling, 2007; Te Pou o te Whakaaro Nui, 2017b; 2018a). In their evaluation of an allied health support and development scheme Solowiej et al. (2010) found the primary concern reported by novice practitioners was the high volume of work required to complete transition programme learning modules. Novice practitioners described this as 'onerous' due to the burden and pressure it created while adjusting to the clinical demands of their new roles (Solowiej et al., 2010).

Feeling competing demands of workload and transition programme requirements were too high was more prevalent for novice practitioners in studies evaluating formal, structured transition programmes (Solowiej et al 2010; Te Pou o te Whakaaro Nui, 2017b, 2018a). For example, programmes that required learning tasks to be completed outside of work and allocated transition programme teaching sessions (Erol et al., 2016; Smith & Pilling, 2007, 2008), or transition programmes that had finite timeframes or financial incentives attached to the successful completion (Erol et al., 2016; Morley, 2009b).

In fact, novice practitioners in both Solowiej et al. (2010) and Smith and Pilling's (2007) studies requested a reduction in transition programme tasks because of the increased workload expected of them during transition. The impact of high transition programme workloads, in conjunction with managing clinical practice demands, was a barrier to successfully completing transition programmes that negatively impacted novice practitioners' experiences of transition and of transition programmes themselves (Erol et al., 2016: Solowiej et al., 2010). Studies that evaluated more informal programmes, such as those based on peer support alone or where

transition programme tasks were integrated within usual supervision practices, did not report novices experiencing the same challenges of high volumes of transition programme work (Fitzgerald et al., 2015; Liddiard et al., 2017).

There was significant variation across the literature as to what constituted an appropriate balance of transition programme tasks and clinical caseloads for novice practitioners during the transition; however, the consistent message from novice practitioners was that transition programme workloads were too high and were considered overwhelming (Te Pou o te Whakaaro Nui, 2017b, 2018a). Recommendations have been made for novice allied health practitioners to have reduced or less complex caseloads for the first 6-9 months of transitioning to clinical practice to facilitate a successful entry to clinical practice (Hunt et al., 2016). This may be even more essential for novice practitioners adjusting to the demands of becoming a healthcare professional while attempting to meet the expectations and associated workloads required within transition to practice programmes.

Lack of Protected Time

Maintaining a balance between work, study, and life has been identified as challenging for novice practitioners (Toal-Sullivan, 2006). Allocating protected time to complete transition programme activities was a common component of formal transition programmes or preceptorship initiatives (Banks et al., 2011; Morley 2009a; 2009b; Te Pou o te Whakaaro Nui, 2018a). This practice is intended to support novices completing transition programme learning tasks during work hours and when preceptorship support is on hand (Morley 2009a; 2009b; Te Pou o te Whakaaro Nui, 2018a). However, across most of the literature, novice practitioners described having few opportunities to utilise protected time to complete transition programme tasks. This was further hampered by poor organisational understanding of transition programme requirements, or when clinical practice demands overrode novice practitioners' needs to complete transition programme tasks (Te Pou o te Whakaaro Nui, 2017b, 2018a).

There were inconsistencies as to whether novice practitioners could practically access allocated protected time for transition programme activities. Novice practitioners in both Aotearoa New Zealand and the United Kingdom describe 'theoretically' having protected time but utilising this would never eventuate (Morley 2009a; 2009b; Te Pou o te Whakaaro Nui, 2018a), which left novices using annual leave, requesting additional time off work to complete study, applying for assignment extensions, leaving the transition programme, or novices completing transition programme activities in their own time (Banks et al., 2011; Erol et al., 2011; Te Pou o te Whakaaro Nui, 2017b, 2018a). Banks et al. (2011) posited organisations had

a greater responsibility to ensure fostering an 'ethos of support' for novice practitioners completing transition programmes. They recommended creating policies and practices to safeguard protected time and maintain reduced workloads to allow novices to engage in transition programme tasks during work hours (Banks et al., 2011).

Accessing Preceptors

Despite being highly valued, novice practitioners described preceptors having limited time to dedicate to preceptorship due to their own clinical workloads. This reduced opportunities for preceptors to observe novices' practice or regularly engage and assist novices with transition programme activities (Banks et al., 2011; Erol et al., 2016). Preceptors also stated this was a barrier impeding the provision of effective preceptorship and supporting novice practitioners' professional development during transition (Erol et al., 2016; Morley 2009a, 2009b). Having sufficient time allocated to commit to preceptor roles was suggested as imperative for preceptors to provide more effective support for novice practitioners completing transition programmes (Erol et al., 2016; Morley 2009a, 2009b).

Banks et al. (2011) further highlighted a need for preceptors to better understand their roles within transition programmes and to receive training to enhance their preceptorship skills in order to address the needs of novice practitioners undertaking transition programmes. Supervisors and preceptors in Morley's (2009b) study proposed creating a preceptorship peer support forum to network with each other, deepen understanding of their roles and responsibilities, and provide more tailored and effective preceptorship support. This initiative has potential implications for transition programmes and future research, as when novice practitioners received effective preceptor support they were more likely to successfully complete transition programme requirements (Banks et al., 2011; Erol et al., 2016).

In summary, despite utilising allied health transition to practice programmes as vehicles for easing the transition to clinical practice, there remains significant variation and inconsistencies across the literature reviewed as to what types of transition programmes are best placed to support novice allied health practitioners during the transition. This was reflected in the variety of transition to practice programmes detailed within the current published literature pertaining to allied health transition programmes. Notwithstanding the lack of uniformity of transition programme structures or components, there were significant benefits novice allied health practitioners gained from participating in transition programmes which included peer support, networking, support from preceptors and supervisors, increased confidence and competence, career progression and advancement, and funding and financial incentives which supported successful transition programme completion. Overall, the transition programmes

deemed most beneficial were those that incorporated a variety of teaching/learning strategies, facilitated novice support networks, provided technical knowledge, encouraged wider professional disciplinary understandings, and were well supported at all levels of an organisation.

Transition programme challenges novice practitioners encountered appeared to stem from employers holding little knowledge of transition programmes or when programmes were not well supported in the workplace by a positive learning culture. Additionally, novice allied health practitioners having high or complex clinical workloads, in conjunction with significant transition programme learning demands, were barriers to novices successfully completing transition programmes or feeling programmes were not valued. Programmes most valued by novice practitioners were those with a clearly defined end point that were acknowledged through formal ceremonies, financial means, or career advancement; and that recognised novices progression to competent health professionals.

Although there were limitations to the research included in this review, examining the available qualitative research has started to reveal insights into novice allied health practitioners' experiences of transition to practice programmes, including the benefits gained and the challenges encountered. Further research exploring the perspectives of novice allied health practitioners undertaking transition to practice programmes internationally seems warranted to address the paucity of research in this area and the research gaps identified within this review. The knowledge gaps to which the current study aims to contribute are outlined in the following section.

Section Four: Knowledge Gaps

It is acknowledged that some articles were deliberately excluded from the review. Further, there are limitations to any search strategy with the potential for relevant publications or articles to be missed or omitted. Attempts made to ensure a rigorous and clear search procedure and process were detailed in section one of this chapter. Notwithstanding, it is important to consider that the identification of the research retrieved may in some way be reflective of my own occupational therapy disciplinary perspective, as this lens will have influenced the literature search process.

However, as evidenced by the small range of literature retrieved for this review, there is currently a paucity of literature exploring the perspectives of novice allied health practitioners completing transition to practice programmes. This was a trend, both internationally and nationally in Aotearoa New Zealand, despite recognition of its importance. As such, gaps exist in the current knowledge base. As might be expected, much of the early transition programme

research has focused on pilot studies, evaluations, or examining factors that influenced novice allied health practitioners' successful completion of transition programmes. While more recent research has begun to explore and incorporate the subjective experiences of practitioners to the knowledge base, this has not been examined in depth. Moreover, in Aotearoa New Zealand, this type of qualitative exploration has not been undertaken. This represents a lack of knowledge that has potential implications for practice, education, and workforce development, in part, due to Aotearoa New Zealand's unique cultural and clinical practice context. The current study aims to close this gap.

Additionally, in relation to mental health and addiction practice, only Te Pou o te Whakaaro Nui's (2017b, 2018a) transition programme evaluations focused on this specialist area of practice. While Morley (2009b) recruited two participants from mental health settings, the remaining studies either did not clearly delineate participants' clinical practice areas or focused on primary healthcare settings. In comparison to novices entering mental health and addiction practice, these practitioners may have significantly different transition experiences due to differing workplace contexts, availability of professional support, specialist knowledge requirements, or the demarcation of professional roles within these clinical settings. By focusing on novice allied health practitioners transitioning to mental health and addiction practice, this study provides a distinction. Comparing findings from this study to current literature is hoped to reveal differences and potential nuances in the perspectives of novice practitioners transitioning to specialist mental health and addiction practice in order to justify this distinction.

Furthermore, most research incorporated a diverse range of allied health disciplines, did not explicitly differentiate the professional disciplines of participants, or solely recruited occupational therapy participants. There was no research identified that explored social work novices' experiences of transition programmes. Moreover, only two studies examined participants perspectives of transition programmes with academic qualifications incorporated as a fundamental transition programme component (Te Pou o te Whakaaro, 2017b, 2018a), and these included participants from disciplines outside of allied health, like nursing and midwifery practitioners. To the best of my knowledge, at the time of writing, by focusing solely on practitioners from occupational therapy and social work disciplines, this study appears to be one of the first to explicitly explore the perspectives of these novice practitioners completing mental health and addiction transition programmes within the allied health knowledge base. It also adds to current knowledge the experiences of practitioners completing a transition programme with an academic qualification.

The small body of literature retrieved provided useful insights into the perceptions of novice allied health practitioners undertaking transition to practice programmes worldwide. Analysing the literature thematically indicated that some consistency is emerging within available transition programme research in terms of the facilitators and challenges faced by novice allied health practitioners transitioning to clinical practice. Developing robust evidence investigating how transition programmes support the successful transition to practice is needed as it has the potential to influence future transition programme provision and effect the long-term retention of novice allied health practitioners in mental health and addiction practice. This has relevance for the allied health professions given that negative transition experiences was deemed problematic for novice retention in the literature. It also has relevance for the wider workforce development sector given the current global workforce crisis.

Finally, a limitation of the majority of studies was the lack of diversity amongst the participants which suggests previous research findings may not hold relevance to the broader spectrum of novice allied health practitioners undertaking transition programmes. The current study intended to achieve diversity of participants to address this gap through purposive sampling in order to include the voices of participants of varied demographics (e.g., male/mature/Māori) who may not have been meaningfully represented within previous research.

In summary, a key aim of this study is to explore and maximise insights into the experiences of novice occupational therapists and social work practitioners completing a specialist mental and addiction transition to practice programme. The purpose is to generate knowledge that previous research has not yet uncovered. Extending disciplinary understandings to advance clinical practice is an anticipated expectation of the study. Including research and data from the Aotearoa New Zealand context in the wider international evidence base is needed. Research targeting the mental health and addiction transition programme experiences of novice allied health practitioners appears to be largely non-existent; as is research investigating those with a postgraduate qualification as a core component of the programme. Given the current global mental health and addiction workforce crisis, addressing these gaps seems timely and germane.

Chapter Summary

This chapter has overviewed and critiqued the available body of knowledge describing the transition to practice period and what is currently known about novice allied health practitioners' experiences of engaging in transition to practice programmes. While there is literature supporting the effectiveness of transition programme provision, there is also a clear

need to add the voices of novice allied health practitioners participating in mental health and addictions transition to practice programmes to the evidence base.

Although the literature affirms that transition to practice programmes are important to ease the transition, little qualitative research examining the experiences of allied health practitioners undertaking transition programmes exists specific to the mental health and addictions sector; and even less is known about this area of inquiry from an Aotearoa New Zealand perspective. These limitations and omissions within the research base necessitate the current study. Developing a robust understanding of novice allied health practitioners' experiences of undertaking mental health and addiction transition to practice programme is hoped to add a fresh, current perspective to the available literature with the intent of progressing clinical practice and education within the mental health sector, and improving the mental health transition programme experiences for future novice practitioners.

This chapter, and the literature review itself, form the scaffold (Thorne, 2008, 2016) and strengthen the rationale for this study. Chapter Three, provides a theoretical overview and critique of interpretive description as the chosen methodology underpinning this research. Research methods of data collection and analysis are detailed, in conjunction with cultural and ethical considerations and steps taken to ensure rigour throughout the research process.

Chapter Three: Methodology and Methods

This chapter describes the methodology underpinning the study and the methods chosen to explore the subjective experiences of novice social work and occupational therapy practitioners who successfully completed a transition to practice programme in Aotearoa New Zealand. A qualitative research design guided by interpretive description methodology was chosen to address the research question: *What are novice practitioners' perceptions of engaging in a specialist mental health and addictions transition to practice programme?* A theoretical overview of interpretive description, its philosophical foundation, and rationale for the choice of this specific methodology as the best fit to address the research question are detailed. Methods of data collection and analysis, recruiting participants, and steps taken to ensure rigour are described, alongside key ethical and cultural considerations relevant to the research design.

Interpretive Description: Methodological Overview

Interpretive description is a qualitative research approach that explores phenomena of clinical interest to a discipline and develops insights that can ultimately inform and be applied to real world clinical practice (Hunt, 2009; Thorne 2008, 2016; Thorne et al., 1997; Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004). Interpretive description, with its humanist foundations, is a relatively new methodology that emerged from nursing as a methodological alternative to traditional qualitative research methodologies, which were deemed inadequate to address practice-based questions arising within nursing healthcare practice (Thorne et al., 1997). Since its inception, the application of interpretive description has been extended and presented as a methodology suitable for all applied healthcare disciplines, including social work, occupational therapy, and psychology (Hunt, 2009; Sandelowski, 2000; Thorne, 2008). The use of interpretive description is compatible with the aims of this study which are to identify themes and explore the shared meaning novice allied health practitioners ascribed to their transition to practice programme experiences. The intent is to move beyond the purely descriptive accounts of participants, as would happen with a qualitative descriptive approach (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sandelowski, 2000), and to include further exploration and interpretation as part of the research process (Thorne, 2008, 2016).

An interpretive description methodology sits within an interpretive, post-positivist paradigm (Grant & Giddings, 2002), which seeks to understand and explore meaning, to develop in-depth conceptual descriptions and thematic summaries, to "illuminate characteristics, patterns and structure"' (Thorne et al., 2004, p. 3) to support the translation of research to practice. As an approach, interpretive description draws on aspects of other qualitative research

methodologies, such as grounded theory and phenomenology, but its more applied orientation means being influenced by these, rather than embracing them fully (Thorne, 2008, 2016; Thorne et al., 1997). For example, it is beyond the scope of an interpretive description study to provide an interpretive explanation (phenomenology), produce a theory (grounded theory), or determine a 'new truth'; rather, findings are intended to "delve beyond the words" and make a "tentative truth claim" (Thorne et al., 2004, p. 4) about commonalities of a phenomena.

Professional and clinical knowledge are positioned within interpretive description as legitimate epistemological foundations for qualitative inquiries (Thorne, 2008, 2016). The researcher's own theoretical knowledge and professional expertise are acknowledged and regarded as instrumental to designing and guiding initial research processes, especially when there is little available literature or research (Hunt 2009); as is the case with this study. The flexibility of the methodology allows room for disciplinary relevant questions, such as the research question posed in this study which seeks to advance disciplinary understanding of the novice practitioner perspective, generate new knowledge, and shape future transition programme provision. Coupled with the researcher's clinical knowledge and familiarity with the research evidence, interpretive description provides a theoretical framework that informs the research design and establishes boundaries of a study (Thorne, 2008, 2016). This framework is one that is challenged and continually develops as the research progresses and new understandings are gained (Thorne, 2008). These are crucial elements of interpretive description methodology (Hunt, 2009; Thorne, 2008).

Philosophical Underpinnings

While interpretive description has been criticised for 'method slurring' and not having a clearly defined philosophy or methodological grounding (Bertero, 2015; Neergaard et al., 2009; Stanley & Nayar, 2014; Thorne et al., 2004), key authors (e.g., Hunt, 2009; Thorne, 2008, 2016; Thorne et al., 1997; Thorne et al., 2004) situate interpretive description's philosophical foundation firmly in alignment with constructivist and "interpretivist naturalistic orientations" (Thorne et al., 2004, p. 3). They contend that naturalistic inquiry's philosophical underpinnings (Lincoln & Guba, 1985) provide the epistemological and ontological foundation for interpretive descriptive research design (Thorne, 2008; Thorne et al., 2004). According to Thorne (2008, 2016) key axioms of interpretive description include:

- Knowledge is socially co-constructed. The researcher and participants influence each other; they do 'sense-making' individually of their subjective experience and collectively within social interactions (or the group process) and these cannot be

separated. It takes place in the moment and should be interpreted within the context it was constructed.

- Multiple, sometimes contradictory, realities exist. Therefore, all participants may not agree on their experience of phenomena and will have differing perspectives. There are commonalities and individual experiences of the same phenomena. These are both of interest.
- Findings must be grounded in the data collected and the context that they originate from, not from pre-determined theories or categories (Thorne, 2008, 2016; Thorne et al., 2004).

These assumptions guided implementing an interpretive description methodology and shaped the research design, data collection, and analysis methods selected for this study. Grant and Giddings (2002) contended that methodological congruence far outweighs the importance of determining philosophical underpinnings of research. However, it remains vital to state the philosophical underpinnings and clearly situate the study as part of maintaining rigour and credibility of qualitative research (Ballinger, 2006; Curtin & Fossey, 2007; Nicholls, 2009; Stanley & Nayar, 2014).

As part of methodological congruence, focus group interviews were utilised as the primary data collection source in this study (Neergaard et al., 2009; Nicholls, 2009; Sandelowski, 2000; Thorne, 2008); a technique commonly utilised within health, social sciences, and evaluation research (Kidd & Parshall, 2000). The use of a group context was chosen to elicit deeper thinking, shared reflection, and discussion between participants about their experiences of the transition to practice programme (Ballinger, 2006; Sandelowski, 2000; Thorne, 2008). Individual interviews were considered but not pursued due to wanting to use the social dynamics of participants interacting with each other and the collective meaning making that would develop during group discussion to generate comprehensive insights about the subject of interest (Thorne 2008, 2016). Thus, in line with interpretative description's philosophical and ontological underpinnings, participants would construct their knowledge 'in the moment' through social interaction techniques (Thorne, 2008; Thorne et al., 2004). These interactions within focus groups, including with the researcher, allowed shared perspectives and meaning to be generated during the group process; all core elements of interpretive description methodology (Thorne, 2008, 2016).

Rationale for Selection of Interpretive Description

Fundamental to interpretive description methodology is the understanding that the research begins with a practice-based question which seeks to develop clinically applicable knowledge

(Thorne, 2008). As discussed in Chapter One, this research project emerged from questions raised in my practice as an occupational therapist and clinical educator within a transition to practice programme, specifically around better understanding the needs of novice practitioners transitioning to mental health and addiction practice and progressing transition programme provision. These are the types of practice-based questions that interpretive description seeks to address and reflects the core reasons why interpretive description originally emerged as a methodology (Hunt, 2009; Thorne 2008; Thorne et al., 1997; Thorne et al., 2004).

Using an interpretive description methodology is considered suitable for enquiries where there is little empirical data. As the literature review revealed in Chapter Two, the subjective experiences and perceptions of novice allied health practitioners who have completed transition to practice programmes have yet to be fully uncovered and examined. A naturalistic inquiry research design guided this study to address this gap in the research evidence (Grant & Giddings, 2002; Lincoln & Guba, 1985; Thorne 2008). Clinical experience and curiosity, reviewing the literature, discussion with academics and colleagues, and beginning with a practice-based question, provide a legitimate scaffold which shaped the research question, study design, and initial analysis processes. Thus, this study is aligned with interpretive descriptions theoretical and epistemological foundations (Thorne, 2008, 2016).

Lastly, this exploratory study included interpretation as part of the research process (Thorne, 2008). The interpretation element of interpretive description extends beneath the surface of what is observed, and attempts to uncover patterns and meaning (Thorne, 2016). It does so by asking questions such as 'What is going on here? What does this mean? What am I learning about this?' (Hunt, 2009; Thorne 2008; Thorne et al., 2004). These questions were constantly asked during data collection and analysis. The current study intended to contribute new knowledge and advance disciplinary thought and professional practice by generating thematic understandings and exploring novice practitioners' perceptions and insights as to how the transition programme has influenced their transition to specialist mental health and addiction practice (Thorne, 2008). This process is reflective of core philosophical assumptions underpinning interpretive description that lived human experience and subjective knowledge are key sources of data that can be applied to inform clinical healthcare practice (Hunt, 2009; Thorne, 2008; Thorne et al., 1997; Thorne et al., 2004), and justifies drawing upon interpretive description as a relevant methodology to inform the research.

Methods

The study design and research methods utilised in this study were reflective of the aims and purpose of the research, aligned with interpretive description methodology and were compatible with emergent and inductive research (Hunt, 2009; Kim, Sefcik, & Bradway, 2017; Nicholls, 2009; Thorne 2008). The following section describes ethical and cultural considerations, sampling and recruitment of participants, participant demographics, data collection and analysis processes and steps taken to ensure research rigour, alongside decisions made throughout the research process.

Ethical Considerations

Ethical approval for this study was granted by Auckland University of Technology Ethics Committee (AUTEC) on 29th October 2018, reference number 18/383 (Appendix A). Key areas of ethical consideration for this study included informed and voluntary consent, avoiding coercion to participate, maintaining privacy and confidentiality of participants, and consideration of any conflicts of interest between the researcher and research participants. These were addressed within this study through processes such as the use of recruitment emails, participant information and consent forms, and the processes that participants undertook as part of agreeing to participate in the study.

Informed and Voluntary Participation

Participation was voluntary and participants were not coerced to participate. Recruitment emails (see Appendix G) were sent by an independent party, the transition programme administrator, who was not involved in the study. Participant information sheets (see Appendix H) and informed consent forms (see Appendix I) were included in the email. These recruitment processes were designed so potential participants were well informed about the research yet could decline engaging without the pressure to participate. For example, they could ignore the email and not respond at all; or make enquiries to the researcher or the project supervisor without obligation to proceed further.

Even once consent had been given, participants could withdraw from the study without question, including during focus group interviews. All participants provided written informed consent prior to focus groups commencing. Information regarding withdrawing from the study was repeated during focus groups. This addressed consent issues for participating in focus groups and reminded participants of options for dealing with data records if they chose to leave the study during or after focus group interviews. No participants chose to leave the focus groups or the study.

Privacy and Confidentiality

Due to the research taking place in a group setting, complete anonymity and privacy could not be guaranteed. The informed consent process and consent forms participants signed aimed to minimise risks. Ethical obligations and professional standards for maintaining confidentiality and privacy of participants, and of focus group content, was emphasised at the outset of each group. Confidentiality was maintained by adhering to boundaries as set out in the participant information and consent forms. Participant identifiers and demographic data were removed from data during focus group transcription and pseudonyms were allocated and applied when including participant quotes within the findings of this study.

Recruitment emails and those detailing practical arrangements for focus groups, which included participant details, were deleted once focus groups had taken place. Participants' consent and demographic data forms were stored in a locked cupboard and filing cabinet respectively at Auckland University of Technology (AUT) campus in the research supervisor's office. Electronic data were transferred and stored in a secure password protected folder on an AUT computer during data collection and analysis. Data will continue to be kept securely as required by AUTEC guidelines for six years, after which paper data will be destroyed via a confidential documents bin, electronic data will be deleted, and any external pen drives physically destroyed.

Conflict of Interest

As I practice as a clinical educator on the transition programme there was the potential for conflict of interest if current students were recruited. A purposive recruitment strategy of inviting recent graduates who completed the transition programme during the 2015-2017 academic years was designed to reduce conflict of interest or coercion to participate. Excluding students with whom I had an ongoing role in terms of teaching, supervising, or marking academic work, ensured no conflict between the roles of clinical educator and researcher arose. Steps to reduce power imbalances between participants and myself were managed through the study design with information about the research and consent processes being provided to participants by an independent party, and through consultation and guidance from the university research ethics advisor when seeking approval for the study.

Non-maleficence and Beneficence

It was deemed unlikely that participants would experience emotional harm, distress, or negative consequences from participating in the research. As noted in Chapter Two, previous research and feedback about transition programmes were largely positive and the pilot group

feedback also reflected this stance. However, in accordance with AUTEC guidelines, steps were taken to minimise risks as much as possible as participant wellbeing took priority over collecting research data. As part of reducing risk, distress, or embarrassment, the introductions to focus groups included reminders that it was likely group members would have different perspectives on the topics of discussion, all views were valued, and there were no right or wrong answers.

During groups, if participants showed signs of discomfort, they were offered an opportunity to re-present their point of view and were reminded at the outset of focus groups that they could leave the group at any time or could leave for a short period and then return if they wished. No participants chose to leave during focus group discussions and there was no overt evidence that participants experienced any emotional distress. Details of free counselling services available to support participants were provided in writing and were reiterated during focus groups. De-brief sessions with the researcher or research supervisor were offered but were not taken up. Unprompted verbal feedback from participants after focus groups was positive; with participants sharing they had enjoyed reflecting on their professional journey with peers, contributing to potentially changing the programme, and realising how much they had learnt and grown.

Cultural Considerations

Biculturalism forms an important part of Aotearoa New Zealand society, and as this is the context where this research took place, Te Tiriti o Waitangi principles of participation, protection, and partnership were embedded within the research design (Ministry of Health, 2014). It is acknowledged there have been recent advancements in understanding Te Tiriti o Waitangi and its application within healthcare and education; however, at the time of planning and conducting the current research, this was the accepted framework required by AUTEC to ensure methods for guiding research engagement processes were sensitive and appropriate to meet the needs of Māori and other research participants (Hudson & Russell, 2009). Although this study did not specifically target Māori participants, accessibility and inclusion of Māori was anticipated with purposive sampling. Cultural responsivity was strengthened through the stringent ethical considerations required when seeking approval for the research, supervision, and discussion with Māori research colleagues.

Furthermore, I am of Ngai Tahu descent and hold awareness of Māori cultural customs, beliefs, and values that were integrated within research processes. My own professional and clinical knowledge includes working with Māori and applying cultural customs and processes in practice as part of honouring Te Tiriti o Waitangi commitments (e.g., using whanaungatanga

and karakia within groups). Additionally, professional competency expectations require working within bicultural frameworks and the researcher to be familiar with and competently apply these practices (Occupational Therapy Board of New Zealand, 2015). These are some of the lenses I brought to the research process from a cultural perspective. Steps to uphold Te Tiriti o Waitangi principles within the study are outlined further below.

Partnership

This process began with the invitation to join in the research and working alongside participants during engagement, informed consent processes, and within focus groups. Partnership was enhanced by participants sharing their experiences, their whakapapa (genealogy), whakawhanaungatanga (establishing relationships), and the process of coming together within focus groups. Sharing information about ourselves and our stories, meant strong connections and partnerships were formed, and ensured the participants and I walked alongside each other throughout the research journey.

Participation

Participation was built through facilitating focus group attendance, participants engaging in group discussion and sharing their experiences of the transition programme. Tikanga (cultural customs) such as karakia (prayer) or waiata (song) were offered within group processes to facilitate trust and build connection between participants as part of providing a safe space for participants to engage in the study. Practical processes for enhancing engagement and participation of Māori were incorporated by offering kai (food) within the face-to face focus group and offering koha (gift) to all participants as acknowledgement of their contribution to the study and reparation towards potential costs of attending focus groups.

Protection

Protection was upheld by adhering to pre-determined participation and informed consent processes. Addressing parameters of confidentiality and privacy, and participants' professional and ethical responsibilities for maintaining these parameters within research processes fostered protection of all participants. Creating a culturally safe space by including cultural and spiritual concepts of tapu (sacred) and noa (free from taboo) within introductory group processes, sharing prayer (karakia) and food (kai), as able within focus groups, and being responsive to the cultural needs and wellbeing of all participants throughout this study (e.g., being able to leave focus groups and the study, addressing participant distress, use of tikanga etc.) enhanced protection. Lastly, participants will be provided with a two page summary sharing the findings of the study, ensuring transparency and accessibility of the research to Māori and other participants.

Participant Selection and Recruitment

Sampling Strategy

Purposive sampling was utilised to recruit participants. This non-probability sampling strategy is commonly applied in qualitative research and is congruent with interpretive description methodology (Thorne, 2008, 2016). It informed the recruitment strategy and ensured inclusion of participants who were able to comment on the phenomena of interest and could, therefore, contribute meaningfully to the aims and purpose of the research project (Hunt, 2009; Thorne et al., 2004). The use of purposive sampling supports exploring and examining an aspect of lived, human experience (Hunt, 2009; Thorne, 2008; Thorne et al., 1997; Thorne et al., 2004); and, in this study, was used to expand understandings into the experiences of novice practitioners who have completed the transition to practice programme. Kitzinger (1994) recommended striving for homogeneity when selecting participants for focus groups to ensure robust discussion and interaction between participants and to maximise insights into their perceptions of the subject of interest. Given that the transition to practice programme had not been undergone significant changes in delivery during 2015-2017, purposive sampling ensured a relatively homogeneous experience of the transition programme for potential participants and that the study would include only allied health professions.

Purposive sampling was anticipated to provide diversity that would account for both commonalities and differences within the data during analysis (Thorne, 2008, 2016; Thorne et al., 2004). Establishing broad inclusion and exclusion criteria ensured diverse recruitment of participants including varied demographics such as professional disciplines (social work/occupational therapy); gender; ethnicity; varied areas of clinical practice (e.g. forensic, child and adolescent, drug and alcohol etc.), length of time in practice; and the varied life experience, contexts, and subjective perspectives that participants brought to the discussion. While this ensured common ground and anticipated shared patterns or themes in participants' experiences, it also allowed for "unique manifestations" (Sandelowski, 2000, p. 388) to emerge. The varied perspectives related to the participants' individual experience of engaging in the transition programme were uncovered within the focus groups. Although Māori and other ethnicities were not specifically targeted, the sampling strategy was anticipated to support inclusion of Māori within the study. One Māori participant was recruited alongside participants from a diverse range of ethnicities. Purposive recruitment of recent graduates of the programme also safeguarded against any ongoing professional role I may have had with participants as a result of teaching on the transition programme, and reduced any conflicts of interest or coercion to participate.

According to Thorne (2008, 2016) there is no set formula as to what constitutes appropriate sample size for interpretive description studies. Instead, the research needs to detail the decision-making processes influencing this aspect of the study design. This was a small-scale exploratory study designed as part of fulfilling the requirements of a Master's thesis project. This meant there were parameters and restrictions in terms of timeframe for completion and resources available to complete this study (e.g., finances and supervisory support). As a result, it is acknowledged that the size and breadth of the study is restricted (Thorne 2008). Thorne (2008) contended these types of research are "justified in having set some arbitrary sample limits" (p. 98); however, stated they must also consider the impact and limits this places on findings, and acknowledge that these parameters mean there are further aspects of the phenomena that could be explored.

Inclusion Criteria

Criteria for including participants in the study were based on the aims of the research and the research question. Participants were eligible for the study if they met chosen inclusion and exclusion criteria (see Appendix J). The primary criterion for participant inclusion was being a social worker or occupational therapist who had graduated from the transition programme during 2015-2017. This ensured that participants were still relatively 'close' to their experience and could share their perceptions of completing the transition programme in its entirety, aligning with the focus of the research and the subject of interest. It also had to be logistically viable for participants to attend focus groups and they needed to be fluent in English to engage in focus group discussion in order to contribute to data collection. While these criteria were influenced by budget constraints—using interpreters was not financially viable—they were principally due to the impact on the research and group processes, the engagement of participants in the group, and the concern it may threaten the rich description that an interpretive description approach to knowledge generation attempts to achieve (Thorne, 2008, 2016).

The initial locations of focus groups (Auckland and Christchurch) were chosen to be accessible and financially feasible for participants to attend. I also had access to free meeting spaces to conduct focus groups within these locations; providing flexibility when scheduling groups and reducing research costs. The internet access criterion was added after deciding to use videoconferencing to conduct the second focus group. This was driven by challenges encountered with initial participant recruitment and realising that participants who volunteered to attend were from varied geographical locations. Facilitating attendance of these participants at a single centre would have been time consuming and far beyond the resources and budget of this small-scale study to implement (Thorne, 2008, 2016).

Participants were excluded from the study if they had not successfully completed the transition programme; thus, not being able to comment on the subject of interest. It was also deemed inappropriate to contact practitioners who had withdrawn from the programme as those that withdrew had done so because of extraordinary personal circumstances and may have been particularly vulnerable. Graduates of the transition programme during 2014 or earlier were excluded as the length of time since completing the programme meant they may have progressed well beyond the parameters of a novice practitioner (Te Pou o Te Whakaaro Nui, n.d.) and would potentially recall less about the programme; therefore, potentially being unable to comment as meaningfully on their experiences of the transition programme. Not having access to current contact details of graduates who completed the programme prior to 2014 was an additional factor influencing this decision.

Excluding trainees from 2018 onwards reduced any ethical conflicts of interest and minimised the likelihood of any ongoing relationship between myself and participants. It also related to the timing of submitting the research proposal and initial concerns that data collection for this study may commence during the 2018 academic year. A further factor was during 2018 there was a significant alteration made to transition programme enrolment criteria and novice nurses were allowed entry into the transition programme for the first time. A broader inter-professional mix of disciplines taking part in the programme may have resulted in a significantly different experience of the transition programme than participants from previous years. As the intent of this study was to specifically explore the perceptions of allied health practitioners, due to the limited research evidence relating to these disciplines revealed in the literature review, 2015-2017 was deemed an appropriate timeframe to apply. It allowed a sufficient pool of transition programme graduates from which to recruit potential participants, and excluded nursing novices as participants to ensure the research focused on allied health professionals, the key purpose of the inquiry. 134 allied health clinicians graduated from the NESP programme during 2015-2017 and were invited to participate in this study.

Participant Overview

Nine novice practitioners were recruited across Aotearoa New Zealand from three metropolitan cities. Six participants were from Christchurch, two from Dunedin, and one from Auckland. Participants ranged in age from 24-54 years; seven were female and two were male. There was a diverse range of ethnic backgrounds—six participants identified as New Zealand European or Pakeha, one identified as Mexican, American, New Zealander; another identified as Māori and New Zealand Pakeha; and one as Fijian. Five occupational therapists and four social workers participated in this study.

Participants were recruited from each of the academic years of interest to the research inquiry: one from 2015, two from 2016, and six from 2017. Of the nine participants, six completed the transition programme in their first year of clinical practice after graduating from undergraduate training programmes. One participant completed the programme in their second year of practice, one in the third year following graduation, and one completed the programme after six years working in physical practice and was transitioning to mental health practice. Five participants occupied intern roles when undertaking the transition programme. Participants were working in varied mental health and addiction services, including child and adolescent, adult inpatient and community, forensic, and private practices. Pseudonyms were used as part of maintaining participant confidentiality and were selected alphabetically, from A to I, from Google lists of popular baby names so no significance was placed on identifiers chosen.

Demographic Data

Thorne (2008, 2016) recommended the inclusion of collateral sources of data to augment primary data collection processes. This supports the research process by garnering a deeper understanding of the phenomena of interest and 'enrichens' the data and subsequent interpretation and analysis (Thorne, 2008, 2016). Demographic information was obtained from each participant to add depth and because of the underlying interpretivist assumption that understanding a person's context provides an opportunity to understand their subjective construction of meaning and the perceptions they hold regarding their own experiences (Crotty, 1998; Kelliher, 2005). The information collected from participants is detailed in Table 1 and includes their age, year completing the post-graduate transition programme, length of time in clinical practice at the time of the focus group, and current clinical roles or relevant clinical experience. This information was captured by participants completing a demographic data form prior to focus group commencement and was expanded further when participants introduced themselves as part of the whakawhanaungatanga processes engaged in at the beginning of each focus group.

Table 1.

Demographic Overview of Participants

Pseudonyms Identifiers	Age	Ethnicity as described by participant	Gender	Professional Discipline	Year completed AH NESP	Years in practice	Current role	Other:
P1 - Ava	26	NZ Pakeha	F	OT	2017	5	CAMHS/CM 1-day Adv Therapy	NESP 3rd yr; Exp: adult Outpt/inpt adult rehab
P2 - Brooke	24	NZ	F	OT	2017	3	Adult Inpatient and Community/OT Role	Completed NESP 1st yr of practice; Intern role
P3 - Chloe	32	Fijian	F	SW	2017	3	Forensic Inpatient SW	NESP 1st yr of practice; Intern role; Other: EPI
P4 - Daisy	39	NZ European Pakeha	F	SW	2015	5	SW/Case Manager Adult Community	Intern role first yr of practice with NESP
P5 - Eddie	32	Mexican American/NZ	M	SW	2016	4	Adult Community Case Manager	Completed NESP 1st yr of practice; Intern role
P6 - Frankie	36	Maori/NZ Pakeha	F	SW	2016	4	SW Case Manager Community	Completed NESP 1st yr of practice;

							Adult	Intern role
P7 – Gendy	29	NZ European	F	OT	2017	3	CAMHS – Community	Completed NESP 1st yr of practice
P8 - Harriet	37	NZ European	F	OT	2017	9	Private Practice Sensitive Claims	NESP after 6 yrs. acute physical; now 3yrs MH
P9 - Isaac	54	Pakeha	M	OT	2017	4	Community MH Case Manager/OT	Completed NESP in 2nd yr of MH practice

Recruitment

Recruitment drives for participants were conducted at regular intervals over a 12-month period. Potential participants were contacted by an email sent by the transition programme administrator with an electronic advertisement and invitation to participate in the research project (Appendix G). Attached to the email were copies of the participant information sheet (Appendix H) and informed consent form (Appendix I). Those interested in participating were to contact the researcher or project supervisor within four weeks of receiving the email and to complete informed consent forms as part of the engagement process. Follow-up emails were sent four weeks later with a further date for participants to reply by. This process was repeated four times over a 14-month period and resulted in 11 trainees being recruited to attend two focus groups. However, two participants were unexpectedly not able to join the ZOOM focus group, resulting in nine trainees participating in the study.

Recruitment Challenges

The initial recruitment email received no positive responses. Three potential participants from Auckland and Christchurch replied to the follow-up email. The second recruitment drive, sent two months after the first, generated no further participants. This was a significant barrier to the recruitment process. Contacting participants who had responded to initial recruitment drives revealed a significant number of graduates had moved jobs or cities or had changed their contact details since completing the transition programme. As an example, one respondent discussed joining this study with fellow transition programme graduates who stated they had not received the research invitations. Therefore, it was decided to contact allied health leaders and clinicians supporting new graduates within district health boards to request forwarding the research invitation onto practitioners within their respective organisations who had completed the transition to practice programme. This was to ensure dissemination of the invitation to the intended audience and that the invitation was made by an independent party. It also supported continued recruitment of participants and ensured recruitment was conducted in a timely fashion so as not to negatively impact the motivation of other potential participants to take part in the study. Altering the original research proposal was debated within supervision to account for the difference in the sender of the invitation email (e.g., programme administrator vs. graduate support staff/allied health leaders). However, it was decided that this was not required as the invitation was being sent via the same digital means, in the same format, via an independent third party and that this was an accepted method for distributing professional information within allied health networks.

Key clinicians forwarded the email invitation to their professional networks as part of the third and fourth recruitment drives. Additional participants registered their interest to participate

and were then contacted by the researcher. A significant number (n=6) of participants were based within a single metropolitan centre which was accessible to the researcher. Respondents for whom it was logistically viable to attend the focus group at this centre and who met inclusion criteria were allocated to the focus group at this location and contacted to arrange a convenient time and place for the focus group. One participant, who was unable to attend the first focus group due to unforeseen work circumstances on the day the group was planned, was invited to attend the subsequent focus group, which was accepted. A significant period of time elapsed between focus groups. While this was planned as part of methodological decision making, it was also influenced by recruitment challenges discussed previously.

The remaining participants (n=5) who registered interest in participating were based at various locations in New Zealand and one in Australia. Due to initial challenges contacting graduates, the potential cost and feasibility of gathering these participants together, and the time commitment required from participants, it was decided to conduct the second focus group via an online platform. This was anticipated to reduce barriers to attending, increase planning flexibility, and increase the likelihood of the group taking place. For the second group, the participant who lived in the same city as the researcher joined the researcher for the ZOOM focus group to enhance sense of connection and group cohesiveness. The remaining participants joined via the ZOOM digital platform.

Videoconferencing

Online platforms are fast becoming an accepted vehicle through which to conduct research due to the accessibility, convenience, and fiscal benefits of using this type of platform. It is particularly useful when there is a large geographical variability of research participants, like this study (Archibald, Ambagtsheer, Casey, & Lawless, 2019). There were initial concerns raised about using this format such as the impact on the quality of interactions and relationship building within a group context, and potential technological issues. However emerging qualitative research demonstrates the effectiveness of using ZOOM; and some researchers deemed the use of ZOOM actually improves data collection within qualitative research (Archibald et al., 2019; Braun, Clarke, & Grey, 2017; Howlett, 2021). Thus, the decision was made to persevere with this digital format for the second focus group.

During the COVID-19 enforced national lockdowns in New Zealand, the use of videoconferencing rapidly became an accepted strategy for maintaining work, study-life, or family connectivity. At the time this research was undertaken, the use of this technology was not yet well-established, requiring additional consideration assessing the viability and

methodological adherence of using a digital platform. For example, the use of groups in interpretive description is focused on observing and 'seeing' interactions between participants and the meaning making processes of a group setting (Thorne, 2008, 2016). Concerns regarding whether this key aspect of the research strategy would be affected by conducting focus groups in an online format were managed through discussion in supervision and exploration of the literature, while adapting focus group interview plans for digital platform use in the research design ensured continued methodological congruence.

Data Collection

Interview Guide

A semi-structured interview guide with open ended questions was developed to generate discussion, while allowing room for flexibility and responsivity to participants (Nicholls, 2009). The interview schedule was initially informed by Krueger and Casey's (2000) theoretical guide to developing focus group questions and drew on research evidence that had similar research questions and were guided by qualitative research methods and processes (e.g., Robertson & Griffiths, 2009). The interview guide was field-tested and adapted after pre-testing within a pilot focus group (see Appendix K for pilot group interview guide and adjustments made based on participant feedback). Following this, the interview guide was refined through reviewing literature, critical reflection with supervisors and expert clinicians, which ensured the questions matched the methodology and the focus of the research (see Appendix L for initial interview guide).

As an iterative approach to data collection was taken, the semi-structured guide morphed and developed through the project, particularly during initial data collection and analysis phases, from the pilot to the final focus group. The continued development of the interview questions was intended to generate further discussion, richness and depth to the data, and to more explicitly address the research question as the research progressed and data were collected. The interview guide was also adapted for the ZOOM focus group to ensure questions were clear and easy to understand, and that lags in response time or gaps in conversation of participants might be reduced on the videoconferencing platform (Archibald et al., 2019; Howlett, 2021).

A further example of the iterative approach to data generation was presenting emerging themes derived from the initial focus group interview to the subsequent focus group (Thorne, 2008, 2016). Potential themes were noted on the bottom of the interview guide and introduced into focus group discussion, particularly if participants had not already spontaneously referred to these concepts. Questions in the revised interview guide were

deliberately kept broad and followed Krueger and Casey's (2000) guide to questions more closely than the initial guide, like including 'think back' questions to encourage greater reflection (see Appendix M). Discussion prompts were developed and documented on the second interview guide to encourage discussion if the focus group was quiet or initial questions generated little discourse. These questions also supported seeking clarification and developing in-depth insights into the groups' collective perceptions of engaging in the transition to practice programme.

Pilot Group

A pilot focus group was undertaken with the aim of testing the adequacy of the interview guide. This allowed me to prepare and enhance facilitation skills for conducting the focus groups, identify potential issues with planned research procedures and any resources that may be required. It was also an opportunity to review the study design and assess the use of focus group interviews as the best method to address the study aims.

The interview guide and focus group process were pre-tested with a group of five recent graduates of the transition programme who were not eligible for inclusion in this study due to graduating in 2018. This meant it was piloted with clinicians who shared similarities of successfully completing the transition programme, could provide insights into their perceptions of the transition programme, and would be representative of participants who would be selected for this study. The pilot group enabled reviewing clarity of the planned questions, to determine whether questions would generate relevant discussion between participants and address the research question adequately, and to consider whether there were additional questions that needed to be asked. Pilot testing, expert feedback and supervisory guidance resulted in slight changes to the pilot interview guide. For example, this included reducing the introduction to the focus group, the number of questions and the complexity of questions being asked (see Appendix K).

Focus Groups

As a single focus group is deemed insufficient to produce quality, credible research with integrity and rigour (Thorne 2008, 2016) data collection included two focus groups. This reduced the likelihood of falling into the trap Sandelowski (2000) described as having a 'naive overemphasis' on findings if these are generated from a single focus group. Within interpretive description methodology there is an essential step of identifying initial themes from within the data and presenting these to subsequent focus groups to confirm they are reflective of participants' experience of the phenomena of interest (Braun & Clarke, 2006; Hunt, 2009;

Thorne, 2008, 2016). These member checking and verification processes deepen data analysis and are crucial elements of data collection that adds to the credibility of the research findings.

Focus groups were conducted at varied times of the working day to allow ease of attendance for participants within their work commitments. They lasted approximately 85 and 65 minutes respectively. The first group took place at a meeting room in an urban mental health service setting, while the second group was conducted via ZOOM online video conferencing. A week prior to the ZOOM focus group a technology trial was offered so participants could acquaint themselves with the digital platform and problem solve potential technological issues that might interfere with attendance or engagement in focus group discussion. Most participants indicated familiarity with the platform and chose not to attend. The trial was attended by one participant who had limited knowledge of online conferencing and wished to increase confidence navigating the digital platform.

In accordance with literature, the study aimed to have 5-8 participants in each focus group (Kitzinger, 1994; Krueger & Casey, 2000; Thorne, 2008). The first focus group was attended by five participants and the ZOOM focus group was attended by four participants. Two participants recruited to attend the ZOOM focus group were unable to join on the day as one experienced issues accessing the digital platform and the other had an unplanned work event. In total, nine participants took part in the study. The distribution of social workers and occupational therapists within focus groups was not reported as part of maintaining privacy and minimising the risk of identification of participants.

While the second focus group did not meet recommended thresholds for participant numbers (Kitzinger, 1994; Krueger & Casey, 2000; Thorne, 2008), it was decided to proceed as four participants were already in attendance when it became apparent the additional participants could not join the group. This was driven partly by challenges of initial, slow recruitment to the study and because of the length of time between participants volunteering for the study and the groups actually taking place which meant the risk of participant attrition when trying to re-organise the group around the diverse and busy work schedules of mental health clinicians. A further consideration was the potential impact on data collection as a significant period had already passed since the initial focus group took place (i.e. approximately five months). Delaying the second group would have significantly impacted the timeframe for study completion.

Conducting a third focus group via ZOOM was considered; inviting recruited participants who were unable to join the second group to form the foundation of a third focus group and to carry out a final recruitment drive for additional participants. Logistical considerations (e.g.,

budget, time constraints, recruitment challenges) played a role in the decision not to pursue a third group. Moreover, following supervisory discussions and initial analysis, the data collected at this point appeared rich and descriptive and was deemed sufficient for generating conceptual understandings and meaningful findings.

Focus Group Process

Both focus groups were digitally audio recorded and commenced with re-stating the purpose of the research and reviewing confidentiality and consent processes. Ground rules for the groups were established including managing health and safety; and participants' rights such as withdrawing from the study at any time, leaving during the group and the process of the researcher contacting them after the group were re-emphasised. As previously stated, no participants withdrew from either focus group. Participants introduced themselves and were encouraged to use their pepeha (Māori introduction) if they wished. An 'ice-breaker' activity was used to build group cohesiveness, whakawhanaungatanga (relationship), and establish connection between participants.

As part of constant comparison and member checking, preliminary findings from the first focus group interview were presented during the second ZOOM focus group. Participants were encouraged to discuss whether they shared similarities or differences to their own experience of the transition programme. In line with the constructive, ontological assumptions of interpretive description (Thorne, 2008, 2016), member verification strategies were managed within focus group processes by reflecting concepts raised back to participants and checking the meaning and understanding of these in-vivo during discussion within the group context. After each focus group, a card and small koha (gift) were sent to each participant to thank them for their contribution.

I was the sole facilitator of the focus groups as the costs of having the primary supervisor attend focus groups or employing a co-facilitator were not justifiable within this small-scale study. Thorne (2008, 2016) recommended at least two group facilitators are present during focus group interviews: one to facilitate group process and discussion and the other to take notes, observe participants interactions, non-verbal communication, body language, and for coding comparison after the group. Having a single facilitator was managed by documenting debrief notes that considered group setting, participant engagement, and social interaction patterns between participants immediately following focus groups. Debriefing after the ZOOM focus group also considered challenges in observing participant body language and the potential impact of connectivity issues on group discussion. On reflection, including the research supervisor as a second facilitator within the ZOOM focus group may have been

feasible and was a missed opportunity not recognised at the time. This could have deepened data analysis and potentially facilitated the construction of more latent meaning and interpretation of participants' experiences within ongoing supervision sessions.

Data Analysis

In keeping with interpretive description methodology, data analysis happened alongside data collection with each iteratively informing the other (Hunt, 2009; Thorne, 2008, 2016). Thorne (2008) recommended using multiple methods of data analysis to deepen the analysis and strengthen the interpretation of data; in this study, methods included thematic analysis, memo-ing, mind-mapping, and diagramming. The repeated analysis and varied approaches taken to engaging with the data adds to the credibility of the findings of this study. Purposeful gaps took place between focus groups which allowed time for iteration, immersion in the data, listening to recordings, re-reading transcripts, and repeated coding to identify themes (Hunt, 2009). Consistent with interpretive description, themes and codes were not pre-determined, ensuring an inductive approach to thematic development and that categories, codes, and themes were constructed solely from within the data (Thorne, 2008; Thorne et al., 1997).

Thematic Analysis

Thematic analysis is "a method for identifying, analysing, and reporting patterns (themes) within the data" (Braun & Clarke, 2006, p. 6). To remain consistent with the philosophical underpinnings of interpretive description methodology and the exploratory nature of this study, an inductive approach to the data analysis was chosen and Braun and Clarke's (2006) six-step approach to thematic analysis was applied to the data. This approach has flexibility in its application as it is not linked to a particular methodology and is recommended for inexperienced researchers because of its clearly delineated process that informs and supports an iterative approach to data analysis (Braun & Clarke, 2006; Hunt, 2009). It is acknowledged that Braun and Clarke's (2006) work regarding thematic analysis has evolved since its introduction. However, when initially undertaking data analysis in this study, this was the version available to the researcher and was therefore drawn on to guide data analysis processes for the entirety of this project. More recent thematic analysis publications (Braun et al., 2017; Terry, Hayfield, Clarke & Braun, 2017) were later consulted as part of critiquing and deepening data analysis processes and considering the impact of using online platforms within qualitative research. Rigorous supervisory consultation and collaboration were sought at each stage of the analytic process.

Step One: Familiarisation. Actively engaging with the data began with data collection and facilitating both focus groups. Focus group recordings were transcribed verbatim. The initial

focus group was transcribed by a professional transcriber who signed a confidentiality agreement (see Appendix N), while the researcher transcribed the second focus group. Immersion in the data was facilitated by checking transcripts against the recordings for accuracy, recordings were re-listened to and transcripts were read and re-read numerous times; forming a solid foundation for later coding and theme generation (Braun & Clarke, 2006). Though no codes were assigned, this process involved highlighting phrases, words, and data excerpts, and 'noting' points of interest within the data.

Step Two: Initial Coding. Initial codes, relevant to the research question, were assigned across the entire data set and all codes were derived from the data. Extensively reviewing transcripts, attaching post-it notes, and writing reflexive memos facilitated a deeper understanding of participants' experiences and the similarities and contrasts. Field notes, memos, and analytic notes made by myself were not coded to ensure data focused on the content generated from the participants rather than the researcher. To enhance coding skills, I attended a qualitative coding workshop presented by Gareth Terry, a prominent Aotearoa New Zealander researcher experienced in thematic analysis. This workshop supported deepening coding processes and strengthened data analysis in the study.

Initial coding of the first focus group and presenting developing codes and preliminary analysis to the second focus group facilitated constant comparison processes and ensured data collection occurred alongside data analysis. Several rounds of coding were undertaken at this stage, which concluded with refining and identifying codes and collating the data within these codes.

The research process was impacted by the national lockdown in New Zealand in response to COVID-19, resulting in extended periods of not engaging with the data. 'Re-familiarisation', 're-engagement', and 're-coding' of the data was required which involved re-listening to audio recordings, re-reading transcripts, reviewing coding and almost re-starting data immersion and analysis processes. This was imperative to reduce the likelihood of premature coding (Thorne, 2008), which could easily have happened due to feeling pressured to code and develop themes because of thesis submission time constraints. Intentionally repeating this phase, by moving back and forth between familiarisation and initial coding of ideas generated from the data set, supported iterative and recursive processes of data analysis (Braun & Clarke, 2006).

Step Three: Theme Identification. Themes are the output of the data analysis (Braun & Clarke, 2006), and this step was the beginning of organising data into groupings and initial themes (see Appendix O for examples of initial groupings of data). Codes and data were sorted into word documents and tables by collating similar codes; while semantic themes that were

explicit in the data were searched for. Potential patterns and understandings of the sets of data were tentatively named with 'pithy phrases', as encouraged by Terry et al. (2017), that aimed to reflect the content of the groupings of data.

Multiple possibilities for themes were initially identified. Supervision supported reviewing the relationship between potential themes, sub-themes, and levels within themes. Diagramming extended this process and encouraged further questioning that challenged preliminary interpretation of the data and provided opportunities for reorganising and reviewing preliminary themes (see Appendix P for an example of initial theme diagramming). Collapsing themes, re-organising groupings, producing tentative thematic maps, and writing analytic memos deepened the analysis process and progressed a broader conceptualisation of themes and identified potential gaps and areas for exploration. This stage concluded with producing candidate themes and 'loose' theme names that were refined and challenged throughout data analysis.

Step Four: Reviewing Themes. At this stage, the data were understood intimately, and initial theme development had occurred. Progressing analysis required asking additional questions of the data, such as whether themes meaningfully, and usefully, captured the dataset. This prompted returning to the original data and re-coding; a step Braun and Clarke (2006) stated is common practice at this point in data analysis. It also added to rigour as these constant comparison processes supported keeping themes grounded in the data (Thorne, 2008), and ensured themes accurately reflected coding rather than any of my preconceived ideas. Coherence and fit between codes and themes were constantly revised for possible gaps, further clarifying themes.

Writing about emerging themes encouraged deeper analysis. For example, initially four candidate themes were identified. However, reviewing these against the data and codes generated, made it evident one of the candidate themes fit more coherently within another theme and was, therefore, collapsed and integrated. For example, initial candidate theme labelled 'building sense of connection' was integrated into 'suspended entry to practice' (which was later renamed as 'Feeling Supported'), as this was more reflective of being one of the supportive elements within transition programmes that facilitated novices successful transition to practice, rather than an independent theme. Furthermore, subthemes were initially constructed within major findings. However, reflection and analysis determined these as elements of the major findings as opposed to discrete independent entities, so sub-themes were not introduced within the findings of this study. This step concluded with an understanding of what the themes were, descriptors of themes, and by producing a diagrammatical representation of how themes inter-related.

Step Five: Defining and Naming Themes. Theme definitions were clarified, refined, and established through ongoing supervisory debate. Reviewing included data extracts ensured they illustrated the fundamental meaning and understanding of each theme. The central organising principle of each theme was checked for consistency with the data set. Supervisors encouraged using the participants' words to label and capture the essence of each theme in order to stay close to and provide a strong representation of the data.

Step Six: Producing the Report. The final step involved extensive editing, rewriting of themes, reviewing within supervision, and producing a final analytic report establishing the findings of the study. These findings were captured and presented in narrative form that tells a coherent story of the dataset in the following chapter.

Rigour

There remains considerable disagreement in the literature as to how to demonstrate rigour of qualitative research findings (Ballinger, 2006; Thorne et al., 2004). However, Thorne (2008) specifies four key criteria for evaluating credibility and demonstrating trustworthiness of interpretive description studies including: epistemological integrity, representative credibility, analytic logic, and interpretive authority.

Epistemological Integrity

This refers to congruence between the research question and research processes with the epistemological and philosophical assumptions of the chosen methodology (Thorne, 2008; Thorne et al., 2004). A coherent decision-making process detailed how sources of data and interpretive and analytic procedures flowed logically from the research question and the underlying epistemological foundations of the study (Thorne, 2008, 2016). This was demonstrated by explaining how sampling practices, data collection and analysis processes were informed by key interpretive description principles. All process and procedural decisions were reported and were reflective of interpretive description's epistemological view and its "interpretivist naturalistic orientation" (Thorne et al., 2004, p. 3).

Representative Credibility

Achieving representative credibility requires the theoretical claims of the study be congruent with sampling methods and data collection processes employed in the research process (Thorne, 2008, 2016). A purposive sampling strategy of inviting practitioners who had completed the transition to practice programme ensured identifying a homogeneous sample of participants who had knowledge and understanding of the phenomenon under investigation and were representative of the group of interest to the study (Thorne, 2008). Additionally, having diversity of participants was reflected in the demographic details collected such as the

variation of participants' practice domains (e.g., community service, acute inpatient, NGO etc.) and participants' individual characteristics and life experience (e.g., age, gender, ethnicity, time in practice etc.). Consistent with the theoretical claims of interpretive description, these differences between participants allowed for the development of other "unique manifestations" (Sandelowski. 2000, p. 388) related to being part of the transition to practice programme to emerge.

Findings based on prolonged engagement with the data and participants hold increased credibility (Thorne, 2008). In this study credibility was achieved through data collection and analysis processes such as having more than one focus group, interacting in-depth with participants during focus groups, having a significant gap between focus groups to allow familiarity and full immersion in the data, alongside data analysis processes of recursive coding and re-coding (Braun & Clarke, 2006; Hunt, 2009; Thorne, 2008, 2016). Employing multiple methods of data analysis to compare and contrast emerging themes, alongside critical supervisory discussion during thematic development and challenging preliminary themes prior to final data analysis enhanced rigour of the study findings (Braun & Clarke, 2006). Acknowledging limits to findings, as is detailed in the discussion chapter, and to where findings can be extrapolated, was a further way representative credibility was achieved (Sandelowski, 2000; Thorne et al., 2004).

Analytic Logic

Analytic logic in interpretive description studies refers to providing evidence of inductive reasoning processes throughout the study that allow readers to assess the credibility of results for themselves (Thorne, 2008). Explicitly detailing decision-making steps taken to reach the findings supports transparency and provides "the generation of an audit trail, an explicit reasoning pathway along which another researcher could presumably follow" (Thorne, 2008, p. 225). Thorne (2008, 2016) recommended applying a framework detailing the research design and data analysis processes undertaken. This study applied Braun and Clarke's (2006) thematic analysis framework for guiding coding and analytic processes. Detailed records of coding, analytic interpretation, and decision making were kept and contribute to upholding analytic rigour and logic. Including data excerpts when reporting findings and detailing how the analysis and findings reached emerged from the data, so readers can evaluate the interpretation processes for themselves, adds credibility to the study findings (Ballinger, 2006).

Interpretive Authority

The final criteria for demonstrating rigour is showing that the interpretations made in the study are ground in the data, verifiable, and free from researcher bias (Thorne, 2008). Given

the interactive nature of focus groups and the co-construction of meaning that occurs in this context, there is inevitably some influence of the researcher in data collection and analysis processes. Building in systems accounting for reactivity and checking interpretations against those of participants supports interpretive authority (Sandelowski, 2000; Thorne, 2008, 2016). In this study, member checking processes were integrated within research processes by discussing preliminary themes with the subsequent focus group and by summarising and reflecting points raised in-vivo with participants during focus groups to deepen understanding, check intended meaning, and clarify points raised. Supervisors challenged coding processes and emerging themes, further ensuring findings drawn are robust, trustworthy, and that the interpretations remain ground in the data (Ballinger 2006; Hunt, 2009; Thorne, 2008, 2016).

Documenting the researcher's beliefs, judgements, and assumptions about the subject of interest, and actively reflecting on how these might influence the research process, supports managing reflexivity within research (Stanley & Nayar, 2014). Reflexivity was managed through declaring my professional interests and clinical background as an occupational therapist and clinical educator within the transition programme (see Chapter One). Engaging in reflective journaling, recording thoughts and feelings during the research process, keeping field notes, and outlining an audit trial of the interpretation process were all steps taken to ensure interpretive authority. Finally, as a neophyte researcher, and to ensure a quality final report was presented, the analytic processes used in this study were compared against Braun and Clarke's (2006) checklist for conducting quality thematic analysis (see Appendix Q). This conceptual guideline helped shape research processes and informed decision making as to pertinent information to include within the final report, strengthening the quality of this study

Summary

This chapter has provided a theoretical overview of interpretive description and justification for applying this research methodology to specifically address the study's research question. The influence of ethical considerations and Te Tiriti o Waitangi principles on the research design and steps taken to ensure rigour were presented. Detailed examination of the research methods and the underlying reasoning processes that informed recruiting participants, data collection, analysis and interpretive processes, demonstrated that research process decisions made in this study were consistently aligned with, or guided by, interpretive description methodology. The outcomes of this qualitative exploration and subsequent interpretation are described in the following chapter and presented as thematic understandings and insights into novice practitioners' perceptions of engaging in a specialist mental health and addiction transition to practice programme.

Chapter Four: Findings

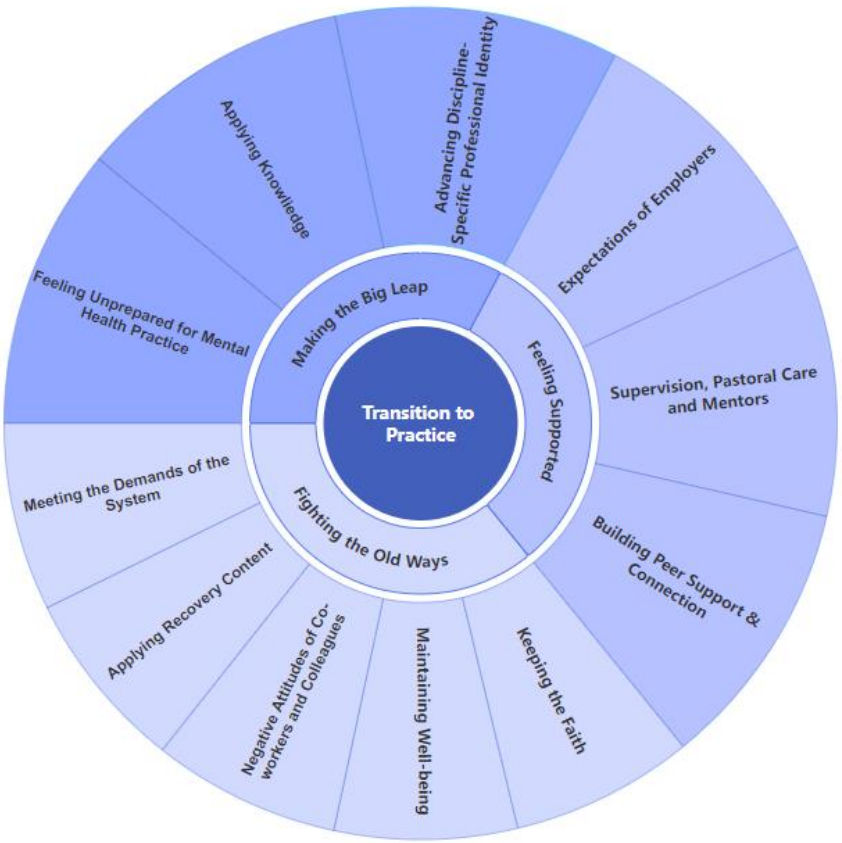
This chapter presents the findings from the study. Findings are presented as three overarching themes—*Making the Big Leap*, *Feeling Supported*, and *Fighting the Old Ways*. These themes were constructed and developed through the analysis process. Given the selected methodology and the intention of the research to explore the perceptions of participants who completed the programme, participant quotes are presented in this chapter to demonstrate the essence of the themes, convey understandings of the themes in the participants' own words, and support the findings. Aligning with the interpretive philosophical stance of the research, a degree of interpretation has been afforded throughout the data analysis process as part of maintaining methodological congruence with interpretive description foundations. A more comprehensive interpretation and discussion of the findings in relation to relevant literature, as well as implications for practice and further research, are presented in the discussion chapter.

The findings from the study were constructed and refined during the thematic analysis of the focus group transcripts. The first theme, *Making the Big Leap,* explored participants' perceptions of making the metaphorical leap to professional practice and factors that impacted the role acquisition process of transforming from an undergraduate student to becoming a competent clinician within the transition programme. The second theme, *Feeling Supported,* described concrete, transition programme conditions placed on participants' employers and the layers of support trainees experienced within the context of the transition programme that created an environment the participants felt was conducive to enabling *the Big Leap* to take place. The third theme, *Fighting the Old Ways,* examined significant tensions and challenges that participants experienced during the transition programme when entering a mental health system dominated by a bio-medical approach to practice, often when applying contemporary, recovery-orientated content from the transition programme into their respective workplaces. A diagrammatical representation of the major findings of the study and how the findings fit together is presented in Figure 1.

In presenting the findings diagrammatically, it should be noted that all three themes are inter-related and there is no greater weight or significance placed on one theme over any other. The findings are, therefore, depicted as connected and reciprocally influencing each other as equal parts. Within each of the findings, there were core components, or elements, that contributed to constructing the themes; each of these is detailed within the themes described below.

Figure 1.

Major Findings of the Study as Inter-connected Themes and Core Elements Constructing Themes



Theme One: Making the Big Leap

The first finding, *Making the Big Leap*, captured participants' perceptions of how the transition programme contributed to navigating the shift from undergraduate student through to participants' eventual transformation as competent clinicians. This theme explored key aspects of participant's experience of the role acquisition process that occurred within the context of the transition programme. It highlighted the importance of recognising and acknowledging the novice practitioner as a clearly defined distinct stage of professional development within and of itself. This finding is perhaps best summarised by Gendy, whose words captured the essence of this theme:

> *I found it really helpful in the transition cos uni to work was such a big transition and particularly in mental health, or probably any area, but it is a big leap in terms of the kind of the caseload or responsibility or experiences that you have.*

Participants described their transition to practice and becoming competent clinicians as being transformative. They described the significant role that the transition programme played in supporting them to progress as clinicians and 'making the big leap' to clinical practice. There

were three key processes within the transition programme that participants identified facilitated making the big leap and successfully transitioning to mental health and addictions practice. These were: 1) recognising participants' feeling unprepared for mental health practice and normalising experiences of the transition, 2) providing relevant mental health and addictions knowledge, and 3) facilitating acquisition of discipline-specific professional identity. Each of these factors will be described and detailed in the remainder of this section.

Feeling Unprepared for Mental Health Practice

Critical to making the big leap was the recognition that participants reported feeling unprepared for mental health practice. Feeling unprepared was evidenced in the ways that participants referenced having inadequate preparation for mental health practice in their undergraduate education. The participants further detailed how the transition programme normalised this experience and facilitated the challenge of making the big leap during the transition to practice. Participants described feeling overwhelmed when starting out in mental health practice and being expected to take responsibility for managing a caseload and the care of consumers, an experience illustrated by Frankie:

> *So, I kind of got left on my own and was given a case load and I was thinking 'oh my god I don't know what to do!'*

Participants recognised the impact that limited exposure to mental health practice within their undergraduate training or a lack of student placements in mental health and addictions had on their readiness for practice. Reflecting the collective experiences of participants as 'feeling unprepared' was illustrated by Daisy when sharing her own experience of generic social work undergraduate education:

> *I think there was very limited, I mean in terms of social worker training, it's very general so there's not a lot of specifics that we go into with mental health and addictions.*

Like Daisy, Brooke described her experience of starting out in mental health practice, identifying gaps in her knowledge, and how participating in the transition programme supported her to reduce her initial uncertainties by providing her with specialist knowledge and training:

> *I was really unsure, and mental health, I mean we only touched on it, it's only part of the programme. It's quite a specialised area so to have training specifically related to that I think was really good.*

A further way that participants described feeling unprepared for practice when making the big leap to clinical practice was described by Frankie as being expected to practice within an unfamiliar clinical framework to which she had not been exposed in her undergraduate

studies. She recognised the lack of specific mental health knowledge provided in her undergraduate training meant she had not acquired the professional jargon and the specialist language used within clinical mental health practice:

> *I suppose in our training for SW and then going into a medical framework, I didn't know the language that well. I think I might have come in knowing 'phenergan'.* (Frankie)

Finally, not being made aware of the realities of the demands of clinical practice was an area Daisy suggested participants could have been better prepared for within their professional training:

> *If you're wanting to look at also being mindful of the reality of working in mental health, it is that pressure. Those [caseload] numbers and the paperwork and all that, so I think maybe having a greater exposure to that.*

Participants reported several ways that their undergraduate training had not prepared them sufficiently for making the big leap. Having further exposure to mental health and addictions practice and the realities of professional practice in general could support participants to feel better prepared and more confident when first making the big leap to mental health and addictions practice.

Participants described participating in the transition programme made them aware other novice practitioners were also feeling unprepared for mental health practice. They realised others were wresting with similar struggles and processes of adjustment to practice. Recognising this and being united with other novice practitioners within the transition programme helped reduce participants' feelings of uncertainty and being unprepared and normalised their experiences of starting out in clinical practice; which Chloe described as:

> *I can't imagine not having that. For me it was probably having the peers that were in a similar situation too. That was really helpful for me, even just knowing they were having similar thoughts or feelings*.

The experience of 'normalising' was named by the participants as an active process of journeying through the transition programme with other novice practitioners, recognising that their experiences of transitioning to clinical practice were common. As such, having their feelings and experiences acknowledged and recognised as 'normal' emerged in the data as an important process that supported participants when making the big leap to mental health and addictions practice. As Chloe highlighted, meeting other novice practitioners during the transition programme provided shared opportunities for the normalisation of uncertainties and worries when transitioning to mental health practice. It also provided participants a sense of relief that they were not alone in their experiences or their professional journeys, as illustrated by Ava:

> *Just knowing other people in similar situations to you and also just riding that emotional wave of being in NESP and just that novice practitioner and things together. Just that real shared experience was really good.*

Critical to successfully making the big leap was the participants' description of the importance of sharing the journey with other novices who held similar ideals and beliefs about clinical practice as a form of coping. Participation in the transition programme promoted participants coping through being *"with people who were of a similar mindset"* (Gendy), who had similar *'values'* about mental health practice (Ava) and, as Isaac suggested, those at a similar stage of professional development:

> *And I think it was also too, being in a group environment with lots of like-minded people who were starting out.*

Journeying through making the big leap with other novices in the transition programme who were experiencing the same pressures and demands and had an intrinsic understanding of the emotional challenges each other were facing, undoubtedly contributed to reducing participants' fears and sense of isolation while novice practitioners. Spending time with other novice practitioners in the context of the transition programme clearly created an environment conducive for the participants to safely share their thoughts and concerns about making the big leap and normalised their own experiences of feeling unprepared when transitioning to practice.

Acquiring Knowledge

"*Because you don't know, what you don't know, right?"* (Harriet)

In addition to feeling unprepared, the participants described how the challenge of making the big leap to mental health practice was facilitated through the provision of technical knowledge and skills that acknowledged participants lack specialist expertise and supported a shift from novice practitioner to competent clinician. The participants described knowledge acquisition as a powerful driver when making the big leap that influenced their successful transition to competent and confident professional practice; in part due to the transition programme providing what Eddie termed "*best practice backed up by research*".

The acquisition of specialist knowledge for practice, such as assessment skills, specialist therapies, and mental health diagnostic and intervention frameworks, provided a form of solace for participants, as well as pragmatic guidance and structure to support their transition to practice. The participants described how transition programme content facilitated them to make the big leap through the advancement of both understanding mental health practice and having skills to begin to function and contribute within the specialist practice context. Brooke

described this as knowledge for "*the everyday"* of mental health practice, which helped her to gain confidence in her own practice during the transition to practice:

> *In terms of knowledge a lot of that really practical stuff was useful like the mental health act or […] the medications or learning the lingo and all that kind of stuff was really practical. The everyday. So, I think NESP was really good to help with my confidence in that way.*

Ava agreed that the programme content related to gaining specialist mental health and addictions knowledge reinforced understandings being acquired from within the clinical practice setting and supported her to feel more confident in her clinical reasoning processes. Furthermore, she recognised the positive influence her growing confidence had on articulating her profession role and forming working relationships with both colleagues and consumers during her transition to practice:

> *I think confidence in your practice in all aspects. Even in your interpersonal relationships with colleagues and confidence in the MDT. Your interactions with patients. Knowing that you've got that understanding and clinical reasoning, which is what you learned in NESP, is underlying what you're doing. I feel that in my first year out you're talking the talk, but you doubt the clinical reasoning behind it, but then the NESP was very reinforcing and helped solidifying that.* (Ava)

Moreover, Eddie recognised that the specialist, in-depth nature of the content of the programme would be difficult to obtain or access independent of the transition programme, commenting *"You can teach the basic structural stuff but a lot of it's quite in-depth stuff you need to be taught from someone".*

Participants comprehensively detailed and listed specific components of the transition programme that supported gaining specialist knowledge for practice and building professional identity when making the big leap to clinical practice. For example, Daisy pointed to "*mental state exam", "risk", "resources", "standard things"* as foundational knowledge acquired from the programme. Other participants specified intervention frameworks and tools, "*the practical, applied stuff*", "*recovery principles"* (Eddie); applying learning in practice (Chloe); and Ava identified "*the wellness plan*" and being able to apply this in practice with consumers. While participants described differing elements of the programme content as supporting their successful transition to practice and professional role acquisition, the consensus of participants regarding the value of programme content was most aptly captured by Frankie, who stated it supported participants "*just learning everything*" to facilitate making the big leap to clinical practice.

Relevant to knowledge acquisition, an additional way that participants described the programme as supporting professional development and role acquisition when transitioning to

practice was the way the transition programme content was structured and delivered. Ensuring that content was provided in a graded, progressive manner that built on previous knowledge was important for facilitating the participants' successful transition to practice, as described by Gendy:

> *I found the structure of it […] the timing of the block in relation to the assignments for me that was helpful. And just the way that it was taught and the way that the block courses were set up. I think the order of the papers made sense too. Because doing that MSE and all that kind of stuff first*.

Isaac pointed to different components such as "*the block courses*", "*study days*", and "*assignments*" as elements that gradually progressed and solidified his knowledge acquisition in the transition programme. Daisy emphasised the structure and variety of the transition programme teaching components as providing building blocks of knowledge for mental health practice within the transition programme learning activities:

> *I think having that foundation from the start. But I also felt like there was that scaffolding of having […] the workshops and the group supervision as well. I think it was really helpful*.

Daisy recognised these methods and approaches—direct teaching, group discussion, completing case studies, being observed in practice, compiling written critical reflections on practice development—provided a framework to guide and augment her knowledge acquisition during the transition to practice.

Furthermore, Harriet discussed the flexibility within the transition programme learning tasks as supplementing her knowledge acquisition when making the big leap and transitioning to mental health practice. She described the importance of being able to adapt assignments, personalise professional development goals, and individualise learning tasks within the transition programme. This supported accumulating pertinent and relevant information for transitioning to clinical practice, irrespective of which areas of mental health practice the participants were practicing in:

> *I really enjoyed that you could make it [learning tasks] specific to the practice area that you were working in. And you had the choice obviously to focus on your practice area or to go somewhere different and that for me helped solidify my practice area in particular*. (Harriet)

In summary, participants described the importance of access to specific mental health and addictions transition programme content for addressing their lack of knowledge and supporting them to make the big leap to mental health practice. Not only was the content of the transition programme significant, but the way in which learning tasks were presented and

the varied teaching methods employed also enhanced knowledge acquisition and facilitated participants' developing competence and confidence during the transition to practice.

Advancing Discipline-Specific Professional Identity

The final way that participants described how the transition programme facilitated the challenge of making the big leap was through the advancement of a discipline-specific professional identity. The significance of developing a discipline-specific professional identity emerged when the participants reflected on the internal shifts they experienced during their transition to practice. This occurred when starting out in practice, trying to come to terms with their professional roles and reflecting on the complexities of these in the context of the transition to practice programme. As Brooke commented, "*I think for me, when I did NESP it was my first year of practice, I think I was kind of feeling my way through it and just trying to figure out what being an OT is all about*".

Participants described how knowledge acquisition alongside the gradual implementation of increased clinical responsibilities within the mental health practice context (a key component of the design of the transition to practice programme) clarified and consolidated understanding about their professional role and responsibilities. This supported participants to advance their professional identity over the duration of the programme, to make sense of their clinical roles and to gain an intrinsic understanding of their respective disciplines:

> *I was really making sense of myself as a social worker and what I needed to be doing.* (Daisy)

Both Brooke and Daisy described the significance of improved understandings about their professional roles as a dynamic process that occurred over the course of the transition programme. Hearing other participants' experiences of practice and what their professional roles entailed further expanded participants' disciplinary understandings and identity:

> *I was thinking it was cool to hear about different workplaces and peoples experience of that from a perspective of 'oh would that be something I would be interested in?'* (Gendy)

Disciplinary identity was enhanced through being with participants of different professional disciplines within the transition programme and extended by having experienced clinicians from a range of disciplines present teaching sessions within the transition programme. This strengthened participants' understanding of their own professional roles through gaining insights into other disciplinary roles and making comparisons with other professionals working in the mental health and addictions practice context:

> *Having other clinicians from different disciplines was good to hear their perspectives as well. [For example] having the doctor who came and talked about medication.* (Eddie)

Participating in the transition programme enabled participants to progressively comprehend and assume their professional roles and identities, supporting them to gradually make the big leap and transition from novice practitioners to more competent clinicians.

Another way that participants described how making sense of their professional roles and identities facilitated making the big leap was through the integration of transition programme knowledge within clinical practice. Participants identified the importance of concurrently acquiring knowledge and being able to apply learning into clinical practice as key processes for consolidating the meaningful acquisition of professional identity. A finding illustrated by Gendy:

> *I don't think it would have been meaningful at all to just do it as a programme without work, because you just wouldn't have the coat hanger to hang any understanding on.*

Application of knowledge in context provided the participants with a structure for their learning and an experiential understanding of carrying out core features of their professional disciplinary roles during transition to practice. Brooke also valued the applied nature of some learning tasks. She described how it made the transition programme content more accessible and relatable, and the important role using her new knowledge in the workplace had for her:

> *I think it was helpful being able to relate it back to your practice though like I know when I was studying for my degree sometimes I found it quite hard to visualise what I was talking about or really understand what I was doing. Whereas because you're able to relate it to what you're doing every day, with some of the assignments, it made it a little bit easier.* (Brooke)

The importance of applying knowledge in practice was mirrored in Isaac's insights into the transition programme supporting him to gain an intrinsic understanding of his professional role. He highlighted the importance he placed on applying learning in practice and then stepping back and reflecting on what he was doing, and how what he was doing, 'fit' with his occupational therapy perspective as strengthening his acquisition of professional identity:

> *It made me kind of reflect on what and how I was practising and what it means to be an OT to be working in mental health. And it did stay with me; I mean that ability to step back and look at the bigger picture and bring it to practice. You know what am I doing as an OT in this role? I am in a generic role now, so I have to really think quite often about how I bring an OT perspective to what I am doing. I thought that was really good about the NESP.* (Isaac)
>
> *So it just strengthened that initial sense of professional identity?* (Facilitator)

> *Yep totally. And reflecting on your practice instead of just doing it and actually thinking about where am I coming from and why am I doing it this way?* (Isaac)

Lastly, participants described how the transition programme content contributed to developing professional identities and supported them to make the big leap through a focus on professional competencies. Ava described how her awareness of regulatory and professional competency obligations within the programme, directly correlated with supporting professional role acquisition in the practice context:

> *I think there were little practical things like for us doing OT competencies. Our goals for NESP, you could directly apply them to what we're expected to do for the Board and things. So, for people in their first year, like someone coming into a new job, you're studying and then that's just an extra thing like at the back of your mind having to do these competencies.*

Further, Harriet described how the transition programme content strengthened her sense of professional identity by providing exposure to evidence-based practice, core tasks of professional practice, and extending her understanding of wider contextual and systemic factors related to mental health practice and her professional discipline:

> *Because I was new to working with in mental health, it was all showing me best practices and documentation and governing bodies and all of that sort of stuff that I wasn't aware of when I was working in physical health because it was so incredibly different.* (Harriet)

Eddie also described how the professional learning he completed within the transition programme consolidated his professional identity and contributed to meeting his professional development requirements for registration, without having to undertake additional development activities: *"Because we had so many hours of professional development, I was covering it [professional development for maintaining social work registration] for a few years!"*

Overall, the participants described how engaging in the transition programme strengthened intrinsic understanding of professional roles and their discipline specific identities when making the big leap to professional practice. Key processes within the transition programme participants detailed as supporting this leap were exposure to other disciplinary roles, applying transition programme learning in practice, expanding understanding of discipline-specific roles in the wider clinical context, and reflecting on professional practice while making sense of their roles over time.

In summary, the first theme detailed key factors and processes within the transition programme that participants perceived were critical to *Making the Big Leap* and successfully transitioning to professional practice in Aotearoa New Zealand. Participating in the transition

programme provided an important function of acknowledging participants felt unprepared when first entering mental health practice. Simultaneously, being with other novice practitioners within the transition programme reduced anxieties and provided a significant normalising function for participants. Transition programme content, such as specialist technical knowledge and the way these were presented and structured, expanded participants' knowledge and skills for mental health and addictions practice. Applying new knowledge in practice assisted the gradual adoption of professional identity and facilitated participants' role transformation from undergraduates to competent clinicians. Participants' experiences highlight the importance of recognising and acknowledging the novice practitioner as a distinct stage of development participants undergo when making the big leap to clinical practice. Participants indicated supportive elements were interwoven with their experiences of the programme, such as being with peers, that also facilitated their transition to practice. As such, these factors are explored further in the second theme, as this focuses on key elements of the transition programme that participants identified contributed to *Feeling Supported* while making the big leap to professional practice.

Theme Two: Feeling Supported

Following on from *Making the Big Leap*, *Feeling Supported* emerged as the second significant finding from the study. In many ways, *Feeling Supported* could be considered central to the findings that come before and after; and, as such, it is presented as the second finding between themes one and three. Participants consistently described how *feeling supported* played an important role in facilitating making the big leap from undergraduates to competent clinicians and for participants to gradually acquire a sense of professional role and identity. The second finding emerged from participants descriptions of the 'sanctuary' provided by the transition programme and the layers of formal and informal support trainees experienced within. Therefore, the first two findings are closely related. Participants *Feeling Supported* while participating in the transition programme, and the essence of this finding, was illustrated in a quote from Harriet:

> *I guess for me it was really supportive is that common theme. For me, having come from working in physical and coming into mental health it was a little bit different as obviously I had that clinical experience and I wasn't a new graduate, but yeah, the support was great.*

Throughout the study participants described various ways that the transition programme contributed to their feeling supported during the transition to practice. Although the experience of feeling supported was common to all participants, participants identified unique layers, or facets, of support that contributed to *Feeling Supported.* Three critical areas of support emerged from the data: 1) the specific expectations placed on participants employers;

2) the formal layers of support provided within the transition programme (such as supervision, pastoral care, mentorship); and 3) informal peer support and camaraderie. The second theme is explored and detailed under these key elements participants identified within the transition programme that contributed to *feeling supported* when making the transition to mental health and addictions practice.

Expectations of Employers

Once a participant had been accepted onto the transition programme, formal expectations were requested of participants' employers to enable them to participate. These expectations included time away from the workplace to attend teaching blocks, study days, and having reduced clinical caseloads for the duration of the transition to practice programme. Ensuring employers have clear information about transition programme requirements, so service managers and colleagues were aware of the needs of novice practitioners participating in the transition programme, was a key facet of feeling supported, as Harriet described:

> *(having) a one page of what to expect so that they know what they are committing to and what the expectation is in terms of giving study days and support.*

Participants described the important role that these formal expectations had on creating a sense of feeling supported when transitioning to practice as a novice practitioner. Gendy described her experience of feeling supported within the transition programme in relation to having service-related flexibility to be able to attend teaching blocks and to take her allocated study days: "*I think, even the things like having the specified days off to be at uni and having study time was really really useful*".

The importance of having permission to be away from the workplace to attend transition programme teaching blocks contributed to participants feeling supported by the conditions placed on their employers. It provided participants with a sense that the transition programme was understood and valued within their respective workplaces, and allowed space for participants' professional learning and development to take place through transition programme conditions being upheld. Daisy described how having permission within clinical time to complete transition programme tasks contributed to her feeling supported:

> *It was during that time on NESP year that we got the scope to go out to other agencies in the community, so if you are a full-time case manager or any other role there probably wouldn't be that scope to do that. There'd be this pressure.*

Daisy recognised that without the formal expectations placed on employers and having protected time to engage in valued learning tasks, these tasks would not have been prioritised or possible. Additionally, Brooke recognised how relationship building with clinicians during

transition programme activities increased her knowledge and understanding of wider service provision. This contributed to her sense of feeling supported through having 'protected time' allowed by her employer to participate in networking tasks:

> *There wouldn't be another way that you'd meet people from the different services you know? Or get an idea of what else is out there and what else the service provides*. (Brooke)

Like Gendy and Brooke, Harriet identified the value of 'protected time' away from the workplace and that having permission from her employer to engage in wider transition programme activities was an important factor in feeling supported. This enabled her to feel better connected to colleagues and wider services through engagement and relationship building with colleagues throughout mental health services across the country that, again, would otherwise not be prioritised:

> *Being able to know who to call and who to connect with in other areas was really beneficial and probably something I wouldn't have looked into further if I hadn't done NESP.* (Harriet)

Another way in which formal expectations around participation in the transition programme supported the transition of the novice practitioner was through requesting upper limits on caseloads for novice practitioners, as described by Ava: "*I think it was just even having thresholds for how many people you pick up and a caseload to manage and things like that*". Daisy agreed that upper limits on caseloads during participation in the transition programme were necessary for novice practitioners to feel supported, and to be able to juggle the demands of study alongside managing clinical practice responsibilities during the transition to practice:

> *You've got this massive caseload. You've got to do all this, but I think being in that NESP year also helped. I think the caseload numbers as well, I mean there needs to be a cap.*

Participants agreed this formal requirement offered a protective and supportive function by giving clarity to employers around caseload numbers for novices, and protecting participants from taking on an unmanageable workload, particularly while they were undertaking postgraduate study.

Furthermore, expectations placed on employers extended to intern or supernumerary roles which some participants occupied. For participants who were interns, feeling protected and supported was facilitated by having boundaries and limits placed around the tasks they were allowed to carry out in the workplace. Chloe described how the expectations placed on employers helped to suspend the expectations of others in her immediate workplace (i.e., managers, team leaders, colleagues) and helped her make prudent decisions regarding her

work tasks and responsibilities. She described the power of reminding her colleagues of the conditions placed around her role, "*I'm the NESP you know... Can't do that I'm the NESP"* (Chloe). Feeling supported by the programme expectations placed on her employer enabled her to feel confident to say no to tasks in which she was not meant to be engaging.

These external expectations also supported participants to manage the clinical workplace dynamic of colleagues pushing organisational tasks onto novice practitioners that they were not ready to undertake due to lack of knowledge or training. The transition programme expectations supported participants to resist this horizontal pressure. Participants described these external conditions and boundaries placed on employers as playing an important role in negotiating internal collegial pressure and managing the expectations of others. This contributed to participants' sense of *Feeling Supported* during the transition to practice.

In summary, protected time and permission from employers, made possible by clear expectations placed on employers, enabled participants to fully participate in the transition programme and to network with colleagues within the wider service. As such, transition programme expectations made of employers was a critical factor that influenced and contributed to participants *Feeling Supported.*

Supervision, Pastoral Care and Mentors

In addition to external expectations of employers, participant experiences of *Feeling Supported* came in the provision of pragmatic transition programme support, such as supervision, pastoral care, and the allocation of mentors in the workplace. Participants described the important role that the extra guidance and care they received as a result of their participation in the transition programme contributed to *Feeling Supported* and facilitating entry to clinical practice. Frankie described how the inclusion of new graduate supervision groups and extra clinical supervision, over and above the standard new graduate supervisory requirements of novices, created a sense of feeling supported within the transition programme:

> *I felt really supported. Even right down to having [DHB new graduate support person] and we had fortnightly supervision and all the different study days that we had on top of having our own supervision with our supervisors. It was massive. I felt really supported.*

In addition to extra supervision, Harriet valued the role that facilitators, staff, and educators on the transition programme played in the creation of a supportive space for novice practitioners. Harriet described the critical role that access to pastoral care provided, and highlighted how this provided a supportive, protective function for her:

> *I remember how accessible you were [clinical educators name]. When I had sick kids and trying to write an assignment and I was sleep deprived and couldn't*

> *see the wood for the trees. And just being able to send that email and have somebody reply who would say 'yep you are on the right track' or 'hey no', 'maybe you need to look at it from this angle'. You and [programme leader name] were fantastic in that respect.*

Similarly, Ava considered the supportive function of pastoral care roles and how feeling supported was fostered through providing the participants with extra support in relation to academic development and guidance. This included individual support such as previewing submitted work and developing academic skills or helping to understanding assignment criteria:

> *You and [programme facilitator] were both so supportive. If you do fail an assignment or whatever then you can re-submit, or you can read them beforehand or your supervisors or preceptors can.* (Ava)

Isaac considered that it was not only the contribution pastoral care made to providing participants with academic feedback and direction with assignments, but also the key role pastoral care played in building a sense of group cohesiveness and bringing participants together that contributed to participants feeling supported during the transition programme and fostered an opportunity for participants to support each other: *"I thought you and [Programme Leader Name] created a nice supportive environment. It was a good environment to learn in and to kind of support each other"* (Isaac).

Like Isaac, Gendy recognised pastoral care as creating a safe sheltered space for participants within the group context when transitioning to mental health and addictions practice. Her experience of the additional layers of support that the transition programme provided within the group context created a sense of support that she described as feeling 'held' by these practices:

> *So, I found it really useful to have that (the support of the transition programme) […] and hearing the experiences of other people who were also in their first year, also new grads, for me it was really holding.* (Gendy)

Participants described formal pastoral care as providing academic guidance and facilitating participants to meet the academic requirements of the transition programme. This was valued for supporting participants through building a sense of belonging and group cohesiveness. Participants' sense of feeling protected and supported by pastoral care was likely facilitated due to knowing there was an additional support person, separate to the workplace, participants could access for support in relation to transition programme expectations.

An additional layer of formal support and guidance participants identified as contributing to feeling supported during the transition to practice, was having clinical mentors allocated in practice as part of the transition programme expectations. Clinical mentors are professional

colleagues in the immediate service setting who assist novice practitioners' learning clinical skills, professional behaviour, to engage in reflective practice, and provide feedback on performance. The importance of having a mentor alongside participants in the workplace added to some participants sense of being supported and protected as described by Chloe:

> *They would give me as much time as I needed, but also being there when I do eventually take that step. So really just seeing where I was at. For me, maybe it is my sort of learning style too, but having a lot of extra support [from mentors], because otherwise I'd just get way too overwhelmed so having that preceptor that was with me the whole entire time was really helpful for me.*

Feeling uncertain in clinical practice situations was a common experience for participants. Clinical mentors supported participants to not become overwhelmed by the stress and pressure of adapting to clinical practice demands when first implementing professional tasks with consumers. Gendy's experience of mentorship extended to having strong discipline-specific role models and allied health leaders in the workplace who provided her with guidance and a practical example to follow; thus, adding to her sense of feeling supported during the transition to practice. Seeing clinical mentors in the practice context meant she was able to 'follow their lead' which added to her feeling supported as mentors paved the way and demonstrated by their actions and attitudes clear professional practice priorities, thus giving her a clear, dedicated professional path to follow. Gendy highlighted the impact of clinical mentors as forming an important facet of novice practitioners feeling supported by the transition programme by the examples they provided in clinical practice:

> *I was really lucky in the setting that I was in too. I had [mentors name] and meeting people like that too, really strong and recovery focused and really strong OT's and seeing that from that mentorship perspective was really good too.*

In summary, the expectations made of employers, in addition to the provision of formal layers of support provided within the transition programme, were significant for participants. These factors contributed to participants feeling supported to actively engage in the transition programme learning and development activities, facilitating their successful transition to mental health and addictions practice.

Building Peer Support and Connection

The third and final way the participants described the transition programme created a sense of *Feeling Supported*, and facilitated the transition from undergraduate to competent clinician, was through building informal supports and connection with other novice practitioners under the umbrella of the transition programme. Participants described connecting with peers during teaching blocks, study days, and spending time with other novice practitioners in the group

context during the transition programme as critical to feeling supported. Peer support was developed through novice practitioners both giving and receiving support from each other within the context of the transition programme. Ava described being introduced to, and linked with, other novice practitioners as one of the most beneficial aspects of participating in the transition programme: *"Connection would be the biggest thing for me probably"*. For Ava, peer support was a core element that generated a sense of feeling supported during the transition to practice

Eddie agreed that connecting with other novices was one of the most positive aspects of the transition programme which lead to him feeling supported during the transition to practice. He described his experience of peer support as building strong collegial relationships with other novice practitioners who were participating in the transition programme, noting *"It was the camaraderie of people going through NESP together"* (Eddie).

Eddie referenced the importance of journeying through the programme and transitioning to practice together contributed to novices feeling supported by the transition programme. Similarly, Chloe described her experience of feeling supported by having other novice practitioners completing the programme alongside her, particularly when meeting with peers in the group setting as *"I liked the group. Having the support and having other people doing it".*

Brooke recognised the importance of *"being surrounded by other clinicians that are just coming into mental health"*, connecting with peers through transition programme activities, particularly valuing the opportunity to learn alongside novices who were at a similar stage of transition as adding to her sense of feeling supported within the transition programme. While Gendy described building meaningful relationships with peers contributed to her sense of feeling supported through the authenticity and empathy that other participants brought to their interactions within the group:

> *It focused on people being able to share their experience and hearing how they were rather than providing a little glossy 'everything's great'. People were genuinely interested in actually what was going on and what were the tensions and how they could support them with that.*

Throughout the programme, and the study, participants shared both their positive and negative experiences of the transition to practice, exposing vulnerabilities and trusting other novice practitioners to listen and support with the challenges they were facing. These shared experiences created a genuine depth of connection and added to participants' sense of feeling supported by peers during the transition to practice. For example, Frankie described the important role that peer support had on helping her cope with challenges encountered during her transition to practice. She highlighted the significance of the peer group support when

feeling overwhelmed and unsupported in her clinical practice, detailing how connection and support from others enabled her to survive this through feeling supported:

> *My first placement they had never had a NESP placement so they were learning too how that would work. And it was also during a time when we were having massive structure change […], so it was pretty intense my first placement. But because of the support I had around me it really helped me get through it.* (Frankie)

Additionally, Ava described the meaning and function of peer support for her as reducing her sense of isolation during the transition programme. This was facilitated through having a fellow novice at the other end of the phone, to contact for practical support, such as requesting resources for clinical practice:

> *Particularly at (DHB ward name) I was quite isolated. Everyone else was over at [large DHB site] and I thought it was really, really valuable for me making those connections for my practice as well as my own wellbeing. Even like picking up the phone and asking do you have this resource? Or do you have something for this or just knowing other people in similar situations to you.* (Ava)

Throughout the study, participants described the key role that brokering relationships with other novice practitioners had on reducing their sense of isolation. Interestingly, all the participants stated that peer support had extended beyond the duration of the transition programme, and continued to influence participants in their present-day practice, as evidenced in these quotes from Eddie and Frankie:

> *So, there were a few of us those who are left. We meet up regularly, so by regularly I mean couple of times a year or something. If we didn't have that NESP we wouldn't have had that connection in the first place.* (Eddie)

> *Two people that I did the course with, one of them, him and I still cross paths and then the other one she is no longer working in the DHB, but we will all catch up for lunch every now and then and its actually awesome. Because we do reminisce and we talk about how we are trying what we are doing, so that part of things has been awesome.* (Frankie)

In summary, employer expectations, formal supports, and peer support and connection were the primary ways that *Feeling Supported* emerged as a key finding from the study. *Feeling Supported* highlighted the important role that relationships have on 'holding' allied health clinicians during the transition to clinical practice, reducing isolation, and sustaining and supporting clinicians as they continue their professional development journeys. Informal peer support and connection between novice practitioners developed over the duration of the transition programme as participants spent increasing amounts of time together completing programme requirements. Getting to know each other over time, sharing their experiences, and creating strong bonds built supportive relationships that supported novice practitioners both during and after the transition programme.

Theme Three: Fighting the Old Ways

Making the Big Leap and *Feeling Supported* detailed critical elements of the transition programme that facilitated participants' successful transition to clinical practice. However, the third and final finding from the study, *Fighting the Old Ways,* evidences the significant tensions participants described from their experiences of entering and working in 'the system', and the negative attitudes they encountered from colleagues. Amongst the myriad of ways participants described these struggles, five significant tensions emerged: 1) meeting systemic demands, 2) applying recovery content, 3) negative attitudes of co-workers and colleagues, 4) maintaining wellbeing, and 5) keeping the faith. Participants' collective perspectives of *Fighting the Old Ways* and the essence of this theme was captured by Frankie when describing the struggles novice practitioners encountered during the transition to practice:

> *There are times that I struggle to be able to do it, but I can do it. And I suppose it's just that you get a bit-tired cos sometimes you are fighting against the tide of older ways.*

Fighting the Old Ways was underpinned by participants' perceptions of the philosophical stance of contemporary mental health service delivery, and the challenges they encountered when applying transition programme content in practice. As discussed in *Making the Big Leap*, the content of the transition programme was highly valued by participants and played a key role in participants successfully transitioning to clinical practice. However, participants' experience of applying these perspectives in practice was somewhat more complex and described as being paradoxical; two contradictory, incompatible parts, one being the "*realities of practice*" (Daisy) and the other being "*the ideal*" (Ava). Throughout the focus groups, the differences between the content taught in the transition programme and the reality of working in the mental health system, emerged as an ideological conflict for participants. Participants described their experiences of the two dominant visions for mental health service delivery—namely the medical model and the recovery model—as almost being mutually exclusive. Daisy illustrated this conflict when discussing the content of transition programme:

> *It [the programme] was good in terms of overall understanding of the recovery model and things, probably just felt a bit more removed from our actual, the realities of practice.*

Like Daisy, participants frequently reported that in the practice setting they were required to complete specific tasks and meet the demands of the system to demonstrate their competence. Conversely, implementing recovery orientated practices was revered by the programme as the 'better way' for improving consumers' experience and outcomes. For participants, this epitomised the divide and the perceived disconnect between the reality, and

expectations, of mental health practice service delivery and what some participants termed the ideal, recovery-oriented practice.

Meeting the Demands of the System

The first tension that participants described encountering as *Fighting the Old Ways* related to meeting the demands of the mental health system and being confronted with the demands of a system dominated by a medical model approach to psychiatry. Participants recounted the excitement and enthusiasm of starting out in both clinical practice and the transition programme quickly being eroded by 'the system' as the demands of practice ate away at their idealism. Participants' experiences of the tension of the reality of practice and striving to provide an ideal or alternate approach were like those described by Ava when sharing her experience of coming up against systemic barriers during her transition to practice:

> *You come in, in your first year and you're real fresh and excited and have all these ideas and then NESP like feeds that almost, which is good. A struggle for me is NESP was really, reinforcing of my own values and then you're up against conflict when you're working in the system that we are.*

Participants identified the deficit-based approach to practice that focused on symptom reduction to measure progress and success, as further contributing to the tensions novice practitioners experienced during the transition to clinical practice. Harriet commented, *"That was some of the challenges of being in a bigger organisation you know that medical model driven, not bio psychosocial, top down approach".*

Demonstrating competence and coping in a mental health practice system driven by a medical approach to mental distress was described by participants as conforming to the system and going along with the 'old ways of practice'. Eddie captured this tension when describing his experience of practicing within a system that did not embrace a wider holistic perspective of health and instead primarily focused on the completion of specific tasks:

> *I did find it slightly frustrating that we were getting taught all this good stuff about recovery principles, and then we're in a workplace where we couldn't apply any of it. And you focus on just doing the requirements, ticking the box ... I said I've got to do what I need to do to keep everybody happy, tick the box.*

Like Eddie, participants described experiencing the mental health system as valuing a task focused approach to practice that left little room for creativity when meeting the needs of consumers. Frankie shared her experience of inpatient mental health service delivery when trying to meet the demands of the system, conveying the unrelenting, repetitive nature of what she perceived as a task-focused approach to care:

> *It just felt like we were just pummelled everyday with all the different requirements that you are needing to complete. There's just task after task and before you know it you are just back at home trying to go to bed to get up and do it all again.*

The participants often referred to the challenges of *Fighting the Old Ways* and the tensions of meeting service-related priorities of the mental health system. These were not necessarily difficulties with mental health practice per se but adapting their practice and ideals to fit within 'the system', almost referring to it as an external separate entity. Brooke described fighting the old ways as focusing on meeting service-related priorities and the pressure to just do the basics, rather than extending her clinical practice lens to include more biopsychosocial interventions:

> *It's the structure of the service that kind of makes it that way. In an acute inpatient unit, it's very fast paced, and the goal is get meds on board, make sure they've got somewhere stable to live and get them home. Trying to broaden that can be hard at times in teams There's a lot of pressure from higher up to make more beds because we've got more people coming in and its really difficult.*

Even with increased knowledge and resource provision, and additional peer and supervisory support when making the big leap to clinical practice, participants shared examples of challenges and tensions of *Fighting the Old Ways* and having to adapt their practice to meet the 'tick box' demands of the mental health system.

Conversely, there was not complete consensus amongst participants regarding meeting the demands of the system being the only valued perspective in mental health practice. Chloe and Ava identified service priorities and the individual values of managers influenced approaches to consumer care based on their different experiences of practice. Chloe's experience was that services with an extended length of stay for consumers were able to extend their lens and focus on providing more extensive supportive services for consumers, allowing practices more reflective of a person-centred perspective:

> *We can have people for longer and there's not such a pressure to push people out because [of] their risks. So, we tend to hold people and do a bit more of a wraparound, so we don't find those same pressures.* (Chloe)

Ava agreed that there was some allowance for divergent perspectives in mental health practice, not just a task-focused approach to meeting the demands of the system, suggesting this tension was also influenced by the values of service mangers in conjunction with service-related priorities:

> *It's so service dependent though isn't it? And who you are working with and what the managers value. But I also think it's what you were saying Eddie, it*

> *depends on the system. When I was at [long-term rehabilitation ward] I felt I had a lot more capacity [to apply recovery concepts] because it is a lot more slow paced and so you have the time.*

Participants like Chloe and Ava, who were further away from acute service delivery, found room within their practice to challenge more medical model established practices. They were able to introduce wider biopsychosocial and recovery focused interventions alongside completing core mental health tasks in their practice. Isaac shared his experience of taking on a new clinical role that was community-based in comparison to the inpatient environment, recognising this allowed him more time and independence in his role to integrate a broader perspective to his clinical practice:

> *In my role now, I have got a lot more autonomy and I am able to do a lot do things a lot more strengths based and in recovery focused ways. And yeah on the ward it was quite different. (Isaac)*

The tension participants experienced when trying to meet the demands of the system seemed to correlate with the closer they were to working in acute inpatient care, the more medical model and risk focused mental health services became. The further away from acute settings participants were practicing, the more opportunities there were for participants to implement interventions from a more holistic, person-centred, client led perspective, suggesting that meeting the demands of the system is closely related to service-setting priorities and that this may be more challenging for novice practitioners placed within acute service settings during the transition to practice.

Applying Recovery Content

The second significant tension participants identified as *Fighting the Old Ways* occurred when participants attempted to apply contemporary recovery orientated programme content into clinical practice. Participants significantly valued hearing the lived experience perspective of consumers accessing mental health services and using strengths based, person-centred ways of working with consumers, as Brooke highlighted:

> *I know I really enjoyed in the recovery paper hearing people's personal experiences and their recovery journey. I found that really useful and I often think back to that as well when I'm working with consumers.*

The participants described how this aspect of the transition programme situated the consumer voice at the heart of practice. Integrating and applying this content in practice resonated strongly with participants' professional and personal values. This was illustrated by Frankie's experience when describing how the recovery content helped her to focus on the clients' perspective and strengthened her resolve to continue to work from a person-centred approach:

> *I loved doing NESP. I enjoyed learning what I learnt. It's highlighted how important it is to acknowledge peoples journey and their experience. It's really put that client-centred focus on and I know that they have to lead me […] I feel like it really gave me an insight into what I need to focus on, and it also strengthened the beliefs that I hold. And it really made me feel why I was doing what I was doing.*

The recovery principles presented within the transition programme provided a vision, an ideal of how practice *could* be. Participants described this as also creating a tension, as this vision was one that participants felt was currently unattainable within the current bio-medical model vision guiding mental health service delivery. Participants described feeling there was no room to apply recovery ideals within the current context of mental health service delivery due to high caseloads, lack of time with consumers, and that the recovery perspective still carries little weight within current mental health service delivery. Eddie's response to fighting the old ways was to stop trying to implement recovery ideals because it had become too hard and too time consuming to action in his clinical work with consumers:

> *The creativity side of it and recovery principles and applying that, no one really cares. When you have so many people you don't have enough time to start trying to think creatively around it. […] I did it in my papers last year and tried to look at how can we be more creative, make it more creative. But it's too much energy to be honest, too much energy and too much frustration and then I was like, oh no I'm pregnant so I'm just going to focus on that.*

Isaac further encapsulated the dilemma and ideological struggle participants faced when attempting to integrate recovery principles in clinical practice:

> *I think learning all that lovely recovery and strengths based focused stuff was great. But then you had to come back to the reality. For me working in an acute mental health ward, under the medical model mostly and it was quite a contrast. It was kind of hard to implement some of those ideas and bringing them back to the 'real world'. I found that quite tough.*

For participants like Eddie and Isaac, coming up against the old ways created frustrations; while other participants like Daisy could not even begin to envisage building recovery concepts into practice as a reality:

> *I think that's what I struggled with. Because I was like how? We've got all these principles, how's it actually going to really fit? And then I remember writing and thinking, how's that actually ever going to be possible in this service?*

These participants had almost rejected applying recovery content practice as it proved tiring and too hard to fight against prevailing attitudes and the old ways. This left participants questioning whether applying recovery orientated practices was realistic, or even achievable, in the current climate of the mental health system. Finding room and creating space to integrate recovery focused approaches within current practice, despite the tensions of doing

so, was explained by Ava. She described applying recovery content and values at a micro level, within individual work with consumers as "*At CAF I feel again it's very different and you're able to do snippets. Your interactions and things can be really recovery focussed but as a whole it's hard*".

In working around the established ways of practice during transition to practice, and integrating recovery principles into practice, participants described resorting to secrecy and almost responsible subversion to use these practices with consumers. Frankie described the tension of knowing it went against the culture of accepted ways of clinical practice within her mental health team, but still tried to apply recovery orientated principles to her work with consumers. She shared feeling only being able to discuss this with colleagues of similar values and beliefs, rather than her wider clinical team:

> *You kind of get drilled into you how you should do this, and how you should do that and then you are kind of like, well I am still not able to. Well, you feel like you're kind of secretly hiding that you have gone out with someone and yeah, I walked around the park and did my review around the park you know? And I try not to tell too many. There are specific clinicians that I might talk to that I know that are on the same page as me of doing things like that.* (Frankie)

While applying recovery concepts in practice 'fits' well with participants' professional ideals, participants reported that carrying out interventions that are not widely accepted has the potential to leave them at odds with service priorities and isolated from other members of their teams. Thus, novice practitioners experience tension and challenges in practice when implementing transition programme content that focuses on more person-centred, recovery orientated practices. Participants detailed a lack of readiness within the mental health system as negatively impacting implementing recovery concepts during the transition to clinical practice, despite their wish to do so.

Negative Attitudes of Co-workers and Colleagues

Another way that participants described having to fight the old ways during the transition to practice was when participants encountered negative attitudes from co-workers and colleagues. Anecdotally, participants referred to 'cynical clinicians' who were not open to different ways of practicing, not prepared to embrace or listen to new research or ideas for practice, and were unwilling to make changes in their clinical practice. Ava spoke about the divide between novice practitioners and experienced clinicians and how exhausting it was to fight against an older view of practice when trying to make changes in the workplace:

> *There's this real conflict or imbalance between the NESP and the new grads and then people who have been working there, and I don't know, that energy*

> *gets sapped so fast! Or even just trying to make change you just come up against so many barriers.*

Participants described experiencing negative attitudes from other staff as a significant hurdle to implementing contemporary approaches to practice in their respective services. Gendy described encountering negative staff attitudes during the transition to practice and highlighted the importance of being introduced and exposed to recovery-oriented principles within the novice practitioner stage as supporting her to overcome this tension:

> *I think too, the really strong recovery focus of the papers that we did was so important for a first year as I think you can so easily get swept up in some of the established practices or more kind of cynical older clinicians and all that. So, for me it was really useful to have that really strong foundation to come back, so that you are building from a place that is really strong recovery focus, rather than just getting sucked into the same ways that aren't always as recovery focused.*

Participants reported experiencing resistance from colleagues when bringing back new knowledge, often recovery content, and attempting to implement these in their clinical practice, or when sharing their ideas during interactions with colleagues in the workplace. Harriet provided an example of attempting to carry out a recovery-based audit as part of the academic requirements of the transition programme and encountered significant resistance from colleagues to her efforts:

> *I couldn't get buy in from other staff. At the time I chose to put out a survey and try and understand people's perceptions, for example for recovery and practice. But I found that other staff who were not responsive to a) what recovery was like – they didn't know. But thought it was a load of rubbish [] So yeah that was really hard. Because it was just seen as the latest fad or whatever and that was some of the challenges of being in a bigger organisation you know that medical model driven, not bio psychosocial, top down approach, yeah everything was just really hard. So that was it, that was a big challenge.*

Isaac described fighting the attitudes of 'cynical older clinicians' as being part of the culture of mental health services and recognised that it may be beyond the capacity of novice practitioners to change these, stating *"It's really hard changing cultures, they are often are really embedded it's really difficult, and there is probably no easy way of doing it"*.

Participants shared eventually capitulating to the rejections from co-workers and colleagues, likely due to the power more established clinicians hold within the clinical practice context. Thus, participants became less likely to share new knowledge and had a reduced sense of agency to implement change in clinical practice. Participants apprised, from the negative attitudes they encountered, that colleagues were often not open to considering new ways of

working or actively placed obstacles in the way of initiatives which meant participants' own enthusiasm for integrating these in clinical practice became diluted and dampened.

Maintaining Wellbeing

A further tension that participants described as *Fighting the Old Ways* was the challenge of maintaining personal wellbeing when participating in the transition programme. Participants perceived self-care as becoming compromised when attempting to fulfil the demands of clinical practice in addition to the academic requirements of the transition programme. Participants' experiences suggest an unwritten, underlying expectation to 'just get on with it' and to meet the demands of the transition programme in addition to adapting to clinical practice, no matter the cost to participants' wellbeing. Participants described not looking after themselves when having to prioritise completing academic assessments and meeting clinical practice demands over tending to their own wellbeing. This created tension and challenged participants' sense that the transition programme was providing them with support during the transition to practice. The essence of not being able to get away from work and study pressures and neglecting self-care to meet the demands of the transition programme was described by Gendy:

> *It was definitely hard. To fit in the study and I found it really draining to have to go home from a full-time role and then to have to study and then spend weekends just with your head constantly in that mental health and OT. To be fair I didn't prioritise self-care as much as I should have, so that would have made a difference, but it was hard.*

Brooke also described the challenge of maintaining wellbeing when trying to meet academic transition programme requirements and fit everything into her schedule. She described having to use all her time outside of work hours to complete academic work as a strategy to manage the demands, rather than using her time for herself or for her wellbeing:

> *I suppose you just end up doing it mostly in your own time you know. Like in your weekends or you get back from work and then you're doing them (assignments). Which is now self-care time, whereas then, it was assignment time. It's kind of always in the back of your mind when you're studying.* (Brooke)

Participants described experiencing the transition programme and the transition year as immersive, all-encompassing, often leaving little or no room for anything else, particularly self-care. Participants recalled feeling the supportive space created by the transition programme was negatively impacted by the high workload expectations and concurrent academic pressures placed upon novices. However, the expectations placed on novice practitioners seemed to be that they would just have to 'manage somehow'. Frankie described the extra

challenge and struggle when having children, families, or external commitments and trying to meet the demands made of novice practitioners on the programme:

> *Yeah it definitely put it into practice didn't it (managing wellbeing)? I found that it was probably one of the hardest things that I have done. Because I've got three children and trying to do the full-time work and manage life with that, honestly, there were times that I contemplated quitting.*

Participants described the tension of having to use their personal time outside of work—time that would otherwise be available for self-care, family, and cognitive distance from clinical work as part of recharging and replenishing motivation for professional practice—to address the competing demands being made of them during the transition. Participants described experiencing stressful times and feeling the supportive aspects of the transition programme were eroded by the volume of work expected of them. This related to the unrelenting nature of postgraduate study for the duration of the transition programme alongside adjusting to the reality of clinical practice and working full-time. Participants' experiences suggest that neglecting self-care and wellbeing was driven by having to meet external expectations which created tension due to feeling overloaded, and that their personal situation was not well understood.

Keeping the Faith

The final tension, keeping the faith, emerged from the participants' descriptions of experiencing hurdles and difficulties in clinical practice when *Fighting the Old Ways* and the tension of trying to maintain a hopeful perspective in mental health practice to cope with the challenges faced during the transition to practice. Participants tried to hold hope for change despite the negative attitudes of colleagues and fighting the old established ways they encountered in mental health service delivery. Trying to keep the faith was a challenge when participants were navigating obstacles experienced in their roles and trying to focus on providing consumer orientated approaches to their interventions and service delivery. Participants recognised trying to maintain hope played an important role both in their work with consumers as well as in their interactions with each other during the transition to practice, potentially assisting them to resist colleagues' negative attitudes and not capitulate to the '*tide of older ways'*.

The tension of keeping the faith closely aligned with exposure to recovery ideals and directly correlated to the transition programme content of hearing the voices of those with lived experience. The lived experience perspective was privileged within the transition programme content and consumer advocates, cultural leaders, and family/whānau perspectives were integrated within academic content presented to trainees. Participants described hearing

consumers' journeys of recovery as some of the most meaningful learning gained from the transition programme. This, in turn, encouraged participants to try to keep the faith and continually strive to improve clinical practice and the experiences of consumers:

> *I don't think I expected there to be such a strong focus on what people's experiences were like. But for me that ended up being one of the most helpful things. Like it wasn't just an academic exercise, it was much more than that.* (Gendy)

Hearing speakers with lived experience who had journeyed from being very unwell through to sharing their recovery stories was an important motivator for participants having hope and keeping the faith themselves. This seemed particularly pertinent for novice practitioners working in acute mental health services who found it challenging seeing consumers at their most vulnerable and when acutely unwell. Trying to remain hopeful was facilitated through participants recognising a consumer being acutely unwell was a temporary state, and that people accessing acute mental health services could progress and make a positive recovery. Brooke explicitly linked her own resolve to hold hope for change in mental health practice in relation to hearing the stories of resilience and recovery of consumers within the transition programme:

> *I mean we work with people every day, so of course it's sort of real. But I think hearing these people have come through quite a large journey, and I know people that I work with are still a lot of the time, still going through a real rough patch. Having people come in and talk about how they've gotten through that, sort of gives you hope as well.*

Hearing the voices of lived experience gave Brooke insights to the needs of consumers she was working alongside in the acute inpatient setting, encouraging her to have hope both for consumers and herself as a clinician working in specialist mental health services. Brooke's experience exemplifies the importance of having consumers with lived experience sharing their recovery journeys as a core part of transition programme content. Hearing consumers' recovery journeys supported novice practitioners to try to have hope despite the challenges of doing so, no matter which area participants practice in when transitioning to clinical practice.

Another way participants described the tension of keeping the faith was when working alongside consumers who were acutely unwell and recognising the responsibility to provide hope for others. Having hope and providing hope supported participants coping with tensions and challenges during the transition to practice when fighting the old ways. Participants realised they had an active role in holding hope for consumers who were experiencing significant distress, such as in the face of reoccurring episodes of active symptoms of mental illness. Daisy talked about the need to give consumers hope that things will improve and get

better when experiencing a crisis. This proved a challenge for participants when struggling to keep the faith for themselves. One way participants navigated this tension was through reinforcing that consumers could build something positive and hopeful out of an episode of illness:

> *I can't remember who it was that came in, but they talked a lot in terms of, and I often use it as well, thinking about when there is crisis there's opportunity as well. And really reinforcing that to people because I think sometimes people can't see that. So, offering that, you know, that there can be those opportunities that come from whatever those situations are.* (Daisy)

A further way in which participants described how keeping the faith supported managing tensions within mental health service delivery during the transition was learning about innovations and initiatives that were being developed within the consumer and peer workforce sector. Isaac described keeping the faith as feeling like he had seen a vision for the future of mental health practice:

> *Hearing the consumers' viewpoint that was really nice. I mean all that kind of recovery colleges and those sort of ideas and peer workers and peer involvement in care. That's not really a thing down here […] they are talking about it at the DHB but it is not really a thing yet which is a shame. So, seeing the future a little bit of peer workers and peer involvement in care was really nice. Just hearing the consumers voice.*

A final way keeping the faith supported participants coping in fighting the old ways was in relation to offering hope to each other as clinicians. This was about continuing to work from what participants considered a hopeful consumer focused approach to mental health care and implementing recovery-oriented ideals in practice. Having hope for change and that change would get easier was offered by Harriet to other participants through sharing her story of finding space to apply recovery ideals within her clinical practice:

> *That has been one of the refreshing things for me actually, leaving the DHB, has been able to implement all of those things and setting up my own practice. And I'm getting people asking me why I am having such good results with the clients. Especially those with their mental health and for me that has been the biggest thing I can attribute it to is the recovery way of working and that is huge. So, it does happen guys. It might not happen in a DHB [but] it can happen.*

Harriet offered her experience of success of fighting the old ways and bringing contemporary recovery orientated approaches into practice as an example to support participants to keep the faith. This encouraged participants to have hope for change, and that the mental health system and service delivery could be changed and improved to include wider perspectives of mental distress and health care interventions.

In summary, participants described significant tensions and struggles during the transition to mental health and addictions practice. *Fighting the Old Ways* was about the barriers encountered by participants when transitioning to mental health and addictions practice and the struggles of applying knowledge gained from the transition programme into the clinical practice arena to meet the demands of the mental health system. This seemed particularly prevalent when participants attempted to implement clinical practice ideals of contemporary recovery-orientated approaches to care for consumers and experienced negative collegial attitudes from 'cynical clinicians'. Maintaining wellbeing was a struggle for novice practitioners when trying to juggle competing demands of clinical practice and transition programme requirements. Keeping the faith and trying to remain hopeful was a final tension woven through participants' experiences in response to the challenges they experienced. Keeping the faith included participants managing the tension of 'holding hope' for consumers when they were struggling to hold this for themselves; 'having hope' that the system can change and become more positive for consumers; and having hope for themselves as clinicians that they can be active agents and improve service delivery through challenging the old established ways of mental health and addictions service provision.

Summary

This chapter has presented the key findings from this study as three themes. The first theme, *Making the Big Leap,* captured participants' perceptions of how the transition programme contributed to navigating the shift of role from undergraduate student through to participants' eventual transformation as competent clinicians. It highlighted the importance of recognising and acknowledging the novice practitioner as a clearly defined, distinct stage of professional development within and of itself. The second theme, *Feeling Supported,* was about the layers of formal and informal support participants derived from participating in the transition to practice programme. Participants described how these layers contributed to feeling supported, and the important role this played in facilitating the big leap to successfully transition to clinical mental health practice. The third theme, *Fighting the Old Ways,* highlighted significant tensions and struggles participants encountered when entering and working in the mental health system during the transition to practice; particularly in relation to older established practices or attitudes within mental health service delivery. The next chapter positions these key findings in relation to existing research and knowledge, and considers the clinical implications of the findings along with strengths and limitations of the study.

Chapter Five: Discussion

The purpose of this qualitative study was to explore novice allied health practitioners' perceptions of engaging in a specialist mental health and addiction transition to practice programme in Aotearoa New Zealand. This final chapter in the thesis seeks to consolidate, interpret, and position the outcomes from the research, including considering implications for future education and practice. The chapter opens with a review of the key findings, then interprets the findings, discusses the potential implications of the findings and the contribution of the research. The chapter concludes by evaluating the research findings and recommending areas for future research.

Summary of Key Findings

As discussed in the previous chapter, there were three key findings of this study that were reported as interconnected themes: *Making the Big Leap, Feeling Supported* and *Fighting the Old Ways.* The first finding, *Making the Big Leap,* encapsulated participants' initial anxieties of feeling unprepared when making the metaphorical leap to professional practice and recognising the significant jump from being a graduate to a healthcare practitioner. Vital transition programme components that progressed participants' confidence and competence during transition included obtaining specialist mental health knowledge, clinical intervention skills, and gaining experience applying this knowledge in practice. These were fundamental elements underpinning acquisition of professional identity that facilitated participants' successfully making the big leap to mental health and addiction practice.

The second finding, *Feeling Supported,* was constructed from the data in the context of participants' feeling 'protected and held' by the transition programme. *Feeling Supported* was facilitated within the transition programme through formal conditions requested of employers allowing attendance at teaching blocks, study days, and having reduced caseloads. Participating in the programme shielded participants from external demands and suspended expectations of others (e.g., employers and colleagues), by creating a sense of time and space for participants to gradually transition to practice. Transition programme practices such as supervision, preceptorship, pastoral care, and building informal connection and camaraderie with peers contributed significantly to participants feeling held and protected during the transition.

The third finding, *Fighting the Old Ways,* highlighted tensions that participants faced during the transition when trying to meet the demands of a mental health system dominated by a biomedical model approach to mental distress and when attempting to integrate contemporary recovery approaches into clinical practice. Balancing high clinical workloads and

post-graduate academic study meant participants struggled to maintain personal wellbeing and self-care during transition. Regardless of these tensions, participants described navigating transition challenges and *Fighting the Old Ways*, by incorporating recovery values in practice, offering each other hope, and holding hope for change in mental health service delivery. Each of these findings is explored in relation to the literature in the following sections.

Transition Programmes Support Transition

Overall, the findings determined that engaging in a specialist mental health and addiction programme supported the successful transition to practice for the participants' in this study. Participants' detailed the provision of technical mental health knowledge and skills, progressing clinical competence and confidence, and developing professional identity as crucial mechanisms through which the transition programme facilitated the transition. These findings closely align with results of a recent study conducted by Joanna Appleby and Dr. Barbara Staniforth who interviewed five social work graduates of the NESP programme in Aotearoa New Zealand (J. Appleby, personal communication, February 24, 2022). Not yet published, their initial findings confirm that completing the transition programme was instrumental in supporting social work practitioners to develop confidence and competence in mental health and addiction practice.

Specialist Knowledge and Skills

Participants' in this study named access to formal education and specialist mental health and addiction knowledge focused on the 'every day of practice' such as mental health and addiction assessment and intervention skills, specialist therapies, diagnostic skills, medication, the language of psychiatry, and mental health frameworks as instrumental to supporting a successful transition. This finding is consistent with existing transition programme research that identifies gaining contextual knowledge and clinical skills for practice effectively supports novice transitions (Banks et al., 2011; Rush et al., 2019). It also signals that the goals of the national workforce development plan (Ministry of Health, 2005) and initiatives instigated within the mental health and addiction sector in Aotearoa New Zealand are being realised through transition programme provision.

Participants detailed how varied transition programme teaching methods progressed their practice knowledge and skills including direct teaching of theory and principles, study days, group-based learning and supervision, applied case studies, and flexibility within assessment processes to adapt evaluations to participants' practice contexts. The scaffolding of learning and the timing of knowledge provision were also identified by participants as key facilitators their learning; for example, presenting foundational mental health practice knowledge *prior* to

introducing philosophical or theoretical practice models; strategies well evidenced within healthcare curriculums to advance students' learning (Hammond & Gibbons, 2005; Layne, McGee, Frank, & Petrocelli, 2021; Naidoo, van Wyk, & Dhunpath, 2018; Rush et al., 2019; Taylor & Hamdy, 2013; Verenikina, 2004). These findings are in keeping with previous literature (Collins, 2004; Gonczi, 2013; Grimmer-Somers, Milanese, & Chipchase, 2011; Taylor & Hamdy, 2013; Torre, Daley, Sebastian, & Elnicki, 2006), and healthcare education research that posit these strategies are critical for advancing novice practitioners' specialist knowledge and skills (Cheetham & Chivers, 2001; Harper & Ross, 2011; Leigh, Whitted, & Hamilton, 2015; Reed et al., 2014; Spies, Seale, & Botma, 2015). Such evidence signifies transition programmes that incorporate these elements would likely be well positioned to support the successful transition to practice of novice allied health practitioners.

Regardless of the positive efforts of the transition programme to advance participants' knowledge for practice, participants reported that transition was compromised by lack of mental health and addiction content in their undergraduate training. Although exploring undergraduate preparation for mental health practice was not a focus of this study, participants referenced this concept in great depth. While it is known that undergraduates often feel unprepared for clinical practice (Gray et al., 2012; Hodgetts et al., 2007; Naidoo, Van Wyk, & Nat, 2014; Nayar et al., 2013; Robertson & Griffiths, 2009), participants' experiences in this study suggest there remains a gap between undergraduate training and professional practice that influences the transition period, particularly in the area of mental health and addiction practice in Aotearoa New Zealand.

The theory-practice gap is well recognised and has been often cited in healthcare literature (Birken, Couch, & Morley, 2017; Brown, 2019; Melman et al., 2016; Tryssenaar & Perkins, 2000). While it is impossible for undergraduate programmes to prepare graduates for every aspect of clinical practice, the findings of this study strongly indicate the need to continue to develop undergraduate healthcare education to better prepare graduates for practice; as previous research has argued (Birken et al., 2017; Happell, 2015; Hodgetts et al., 2007), particularly with regards to mental health and addiction service provision (Ballantyne et al., 2019; Beddoe et al., 2018).

Strategies to achieve this could comprise extending undergraduate healthcare programmes to have increased emphasis on mental health theory, frameworks, and practice models; and for students to have exposure to mental health clinical intervention skills during training (e.g., talking therapies, goal setting, sensory modulation, managing distress, assessment and intervention tools). One such framework sensitive to Aotearoa New Zealand's unique cultural context that could be integrated within undergraduate curriculum to enhance graduate

preparation for mental health practice, is the *Let's get real* framework (Te Pou o te Whakaaro Nui, 2018b). This framework currently underpins the content and provision of the postgraduate mental health transition programme current study participants had completed. It is intended to promote the shared values and attitudes needed for working in mental health and addiction and supports practitioners developing the seven Real Skills (Te Pou o te Whakaaro Nui, 2018b) essential to providing effective consumer care. These skills are relevant to all areas of healthcare and applicable within all health contexts regardless of practitioner roles and include 1) working with people experiencing mental health and addiction needs; 2) working with Māori; 3) working with whānau; 4) working with communities; 5) challenging discrimination; 6) applying law, policy, and standards; and 7) maintaining professional and personal development (Te Pou o te Whakaaro Nui, 2018b). Integrating the Real Skills (Te Pou o te Whakaaro Nui, 2018b) within undergraduate curriculum could support healthcare students developing core skills required for specialist mental health practice, as well as better preparing graduates for transition to practice in Aotearoa New Zealand in general.

Developing Confidence and Competence

Participants contended gaining specialist knowledge and intervention skills was not enough to feel competent or prepared for mental health practice. Congruent with graduate occupational therapists in Australia and Aotearoa New Zealand, participants in this study initially experienced difficulties translating theory and research into practice (Gray et al., 2012; Nayar et al., 2013), which has been shown to be even more challenging for novices entering specialist areas of practice (Brown, 2019). Participants described that applying new knowledge in practice with professional support, and critically reflecting on this with preceptors or colleagues, was an essential factor within transition programmes for advancing participants' clinical competence (Morley, 2009a; Naidoo et al., 2014; Whitehead, 2014); a finding supported by Lee and Mackenzie (2003) who noted that as novices acquire clinical experience, they have a corresponding increase in confidence in their professional abilities.

Participants valued opportunities to apply knowledge in practice which aligns with Knowles' (1984) adult learning theory which asserts adult learners prefer practical experiential learning and teaching practices more collaborative, problem-based, and relevant to their individual contexts (Mukhalalati & Taylor, 2019). While preceptorship is a vehicle utilised within clinical practice for enhancing novices' application of theory in the workplace (Gonczi, 2013; Morley, 2009a; Whitehead, 2014), available literature provides further examples of practical applied approaches utilised within undergraduate training shown to be effective for consolidating student knowledge and preparing students for practice, such as fieldwork placements (Gonczi, 2013; Holmes et al., 2010; Naidoo et al., 2018), role play (Babatsikou & Gerogianni, 2012), and

simulation-based learning (Bruce, Levett-Jones, & Courtney-Pratt, 2019). The findings of the current study imply building novice confidence and competence prior to entering practice through gaining mental health knowledge, and having experiences applying knowledge in context, would likely support graduates feeling better prepared to successfully transition to practice.

Progressing Professional Identity

In addition to providing specialist technical knowledge and progressing participants' confidence and competence, engaging in the transition programme supported participants' acquisition of professional identity. Developing a sense of professional identity during transition has been identified as challenging for novice practitioners (Moorhead, 2019), often due to lack of role clarity (Acker, 2004; Toal-Sullivan, 2006) or not having discipline specific role models in the workplace (Morley, 2009a). In contrast, this appeared less problematic for participants' in the current study as they detailed their discipline-specific understandings were strengthened within the transition programme by hearing other novices' descriptions of practice, their professional responsibilities, and learning about the varied roles novices of the same discipline occupied across the mental health sector. Additionally, networking and building relationships with novice' from varied disciplines within the context of the transition programme facilitated participants gaining insights into their own professional identity by making comparisons between their own and other disciplines; a finding supported by previous research (Zapatka, Conelius, Edwards, Meyer, & Brienza, 2014).

The findings of this study align with those of Smith and Pilling's (2007) case study evaluation of an Australian interdisciplinary allied health transition programme that identified networking; spending time with other novices; and learning from, and about, other disciplines were significant factors progressing novices' professional identity. They also discovered that novices' professional identities were strengthened by having experienced clinicians of varying professional disciplines presenting transition programme education sessions (Smith & Pilling, 2007, 2008). Thus, in conjunction with literature, the findings of the current study indicate transition programmes that provide discipline-specific and interdisciplinary opportunities for networking and knowledge sharing are key to facilitating novices' acquisition of professional identity during transition (Faraz, 2016; Smith & Pilling, 2007, 2008; Zapatka et al., 2014). This finding points to the value of expanding transition programme entry to include novices from all disciplines employed across the continuum of mental health service delivery as a means to enhance novice practitioners' acquisition of professional identity once entering the workforce. As mentioned in Chapter Three, this has already occurred within the NESP transition programme with the introduction of nurses and other disciplines since 2018.

The WHO (2010), in their *Framework for Action on Interprofessional Education and Collaborative Practice*, mandates the shift and need for transition programmes to be less siloed and more interdisciplinary in focus; in part, due to being more reflective of the teams and professional environments that novices encounter in clinical practice (WHO, 2010). Collaborative interprofessional practice has been linked to better standards of care, improved outcomes for consumers, increased practitioner job satisfaction, alongside advancing the professional identities of healthcare practitioners (Rice, 2000). The findings of this study provide rationale for transition programme providers to ensure transition programmes are interdisciplinary in nature in order to progress novices' acquisition of professional identity; the impact of which would likely be strengthened through future research measuring developmental constructs of professional identity during novice transitions, as has previously been explored in the medical profession (Kalet et al., 2017).

Transition Programmes Provide a Protected Space

In addition to the confirmation that the transition programme supports transition, an important study finding was discovering participants felt protected and held within the transition programme. This protection enabled participants to overcome the challenges of transition, develop and progress, and gradually assume their responsibilities as healthcare practitioners. Participants described a protective space was created through the transition programme engaging organisational support, providing preceptorship, pastoral care, and informal support from peers, in addition to usual supervision practices offered in professional practice. These practices reflect key strategies referenced in the literature as supporting novice allied health practitioners during the transition (Opoku, Van Kiekerk, & Jacobs-Nzuzi Khuabi, 2021; Pack 2010; Smith & Jury, 2017), as well as for allied health practitioners undertaking transition programmes both internationally (Banks et al., 2011; Morley, 2009a) and in Aotearoa New Zealand (Te Pou o te Whakaaro Nui, 2017b).

The concept of transition programmes being perceived as 'protective' was not located within the published literature. However, the findings of this study align with Spiva et al.'s (2013) research examining American graduate nurses' experiences of engaging in a structured orientation programme during transition which found novices derived "a sense of being nurtured" (p. 29) from the orientation programme; primarily due to the provision of programme support, preceptor and workplace support, and support from other novices. Transitions are widely acknowledged as a time of vulnerability and change (Melman et al., 2016; Seah et al., 2011) and that participants in this study felt protected and held because of the transition programme supports previous research (Spiva et al., 2013) and extends

disciplinary understandings as to how transition programmes facilitate novice allied health practitioners' successful transition to practice.

Engaging Organisational Support

Participants detailed a protected space being constructed through engaging organisational commitment to place and maintaining supportive structures around novices during transition. Engaging organisational support for transition programmes has formed a key component of the workforce development plan in Aotearoa New Zealand (Smith & Jury, 2017). Aligning with previous research, the findings of the current study found employers providing practical support, such as permission for novices to attend teaching blocks and study days (Smith & Pilling, 2007; Te Pou o te Whakaaro Nui, 2017b), maintaining reduced caseloads (Hunt et al., 2016), and providing professional support in the workplace (Morley, 2009a, 2009b; Turpin, Fitzgerald, Copley, Laracy, & Lewis, 2021) were critical factors fostering novices' feeling protected during transition. Furthermore, Smith and Pilling (2007, 2008) recommended employers could demonstrate support for transition programme objectives by ensuring managers and senior staff are engaged and present within transition programme activities; suggesting this would facilitate a workplace environment more supportive and protective of novices during transition.

In contrast, several studies identified lack of organisational support as a common experience for novice allied health practitioners engaging in transition programmes (Banks et al., 2011; Erol et al., 2016; Morley 2009a). Solowiej et al. (2010) explicitly examined the impact of organisational support on novices' transition programme experiences and found when programmes were not an integral part of the organisation, or not sufficiently integrated within the workplace, novices reported negative experiences of transition. This was compounded when managers and organisational leaders had little or no knowledge of transition programmes or the demands made on novices engaging in these programmes (Solowiej et al., 2010). Based on the findings of this study, and the work of Turpin et al. (2021), this difference may be explained by having transition programme requirements and the expectations made of novices being understood and formally mandated with employers prior to transition programme commencement.

Preceptorship

Participants identified preceptorship as a key component in creating a protected space within transition programmes. The findings highlighted which aspects of preceptorship effectively supported participants during transition and how preceptorship practices contributed to participants sense of feeling protected and held. All participants were allocated a preceptor

who supported participants in applying theory in context, facilitated engagement in critical reflection, provided discipline specific role models, and supported participants to manage the stress and pressure of adapting to workplace demands during transition. This finding supports previous research by Morley (2009a) who found that novices viewed preceptorship more positively when preceptors had a strong understanding of common transitional challenges and supported novices in overcoming these.

A theory relevant to understanding how preceptors facilitated participants' transition is Lave and Wenger's (1991) situated learning theory that posits deeper, authentic learning occurs through experiential learning and utilising knowledge in the context in which it is intended to be applied. In this study, preceptors supported participants applying knowledge in practice which reduced their fears of making mistakes and contributed to participants feeling protected when trialling new learning in practice; allowing in-depth learning to take place. Consistent with research identifying the positive impact of preceptorship for novices (Gonczi, 2013; Melman et al., 2016; Toal-Sullivan, 2006; Whitehead, Owen, Henshaw, Beddingham, & Simmons, 2016) and the links this has to job satisfaction (McCombie & Antanavage, 2017), this study affirmed preceptorship as an essential component supporting and protecting novices during transition and when participating in transition programmes (Banks et al., 2011; Erol et al., 2016; Fitzgerald et al., 2015; Morley, 2009a, 2009b).

Participants in this study were satisfied with the degree and quality of preceptorship support they received during transition which may be related to this practice being supported by, and a requirement of, the transition programme. This differs significantly to previous studies identifying lack of time and access to preceptors as problematic for novices (Banks et al., 2011; Erol et al., 2016; Morley 2009a; 2009b), or literature identifying variable quality in novices' preceptorship experiences due to little time, resources (Gonczi, 2013; Whitehead, 2014), or managerial support being invested to ensure the provision of high quality preceptorship (Whitehead, 2014; Whitehead et al., 2016). Given the importance placed on preceptorship as a core strategy to progress novice practitioner competence, it raises the question of how this practice can be progressed, or even standardised within Aotearoa New Zealand, to better support novice practitioners within transition programmes.

Strategies for enhancing preceptorship practices have been recommended by previous research. In addition to suggesting the need for preceptorship training, preceptors in both Morley (2009b) and Whitehead et al.'s (2016) studies pointed to the potential value of developing a preceptor peer support network by creating a forum for sharing ideas and standardising preceptorship practices. Developing a community of practice for preceptors has also been proposed in the literature (Gonczi, 2013; Lave & Wenger, 1991; Whitehead et al.,

2016). Communities of practice by definition are “groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly” (Wenger-Trayner & Wenger-Trayner, 2015, p. 1), and are based on the supposition that learning is a collaborative process where people mutually guide each other to learn with, and from, each other. Establishing stronger education-practice collaboration through a community of practice offers the possibility of advancing preceptorship quality to better support novice practitioners undertaking transition programmes.

To my knowledge, allied health preceptor peer support networks or communities of practice have not been initiated in Aotearoa New Zealand and are vehicles that would likely progress preceptorship and improve the transition experiences of future novice practitioners, including those engaged in transition programmes. Moreover, the findings of this study support previous research that found having preceptorship formally mandated contributes to positive transition experiences for novice practitioners (Erol et al., 2016; Morley 2009a, 2009b; Turpin et al., 2021; Whitehead, 2014; Whitehead et al., 2016) and affirms the need for formal preceptorship agreements and policies to be developed between the education and practice spaces as standard practice for transition programmes and for supporting novices during transition.

Pastoral Care

Participants described pastoral care and academic support from transition programme staff as integral to forging a protected space during transition and critical to navigating academic and transition programme requirements. It provided a further layer of support, separate to workplace and professional support provided. Pastoral care added to participants’ sense of being protected and held by offering flexible support and timely feedback alongside constructing a sense of group cohesiveness and a ‘safe’ space within the programme for participants to share their transition experiences. This is consistent with Ankers, Barton, and Parry’s (2018) research that found graduate nurses valued support from transition programme staff as it offered “peace of mind” knowing there was support outside of clinical practice, a place where they could “vent, de-brief or off-load” (p. 323) negative practice experiences confidentially or access someone who could advocate for them in practice if needed.

As few studies were identified that explored transition programmes with postgraduate academic components. The current study adds insights into the importance of providing tailored academic support and pastoral care for novices completing similar academic transition programmes, suggesting pastoral care be incorporated alongside other known supportive practices facilitating the transition such as preceptorship (Morley, 2009a, 2009b) and engaging

organisational commitment from employers (Smith & Pilling, 2007; Solowiej et al., 2010; Turpin et al., 2021).

Support from Peers

Participants described support from novice peers significantly advanced feeling protected and held during the transition. Intangible aspects of peer support such as spending time with participants at the same stage of professional development, hearing others' experiences of transition, sharing vulnerabilities, and gaining emotional support eased participants' transition angst. Participants' experiences illustrated the protective and normalising function support from peers can offer novice practitioners when actively facilitated within transition programmes. This aligns with Smith and Pilling's (2007) early work that found transition programme activities based on adult learning principles (e.g., interactive sessions consisting of participation and group discussion) built supportive relationships between novices, allowing the sharing of anxieties and transition experiences in a safe environment; and research demonstrating that peer support reduced novices' sense of isolation (J. Appleby, personal communication, February 24, 2022) and provided reassurance novices' experiences were commonly held (Ankers et al., 2018; Smith & Pilling, 2007).

Furthermore, building strong peer relationships during the transition had the power to encourage participants' continued engagement in transition programmes and remain in clinical practice. Novices often struggle to manage concurrent workload demands of clinical practice and transition programme requirements when inadequately supported (Banks et al., 2011; Erol et al., 2016; Liddiard et al., 2017; Morley, 2009a, 2009b; Solowiej et al., 2010; Te Pou o te Whakaaro Nui, 2018a), and may choose to leave transition programmes or their respective professions (Lee & Mackenzie, 2003; Lloyd et al., 2007; Sutton & Griffin, 2000; Quick et al., 2007). This study affirms existing research by explaining the relationship between peer support, feeling protected, and the potential impact this can have on the retention of novices during the transition period.

The types of activities participants detailed that promoted peer support are commonly discussed in the literature such as new graduate supervision groups (Samara, 2006; Staniforth & McNabb, 2004), small group activities (Smith & Pilling, 2007), new graduate study days (Ankers et al., 2018), and facilitated peer support groups separate to classroom-based learning that allow novices the opportunity to de-brief with peers (Liddiard et al., 2017; Melman et al., 2016). Ankers et al. (2018) further pointed to the importance of developing structures in clinical practice such as debrief sessions with experienced staff at the end of the working day to promote practitioner resilience and facilitate emotional support between novices.

The findings of the current study imply a greater sense of protection and support is promoted if peer support occurs in-vivo and is externally facilitated by experienced clinicians or transition programme staff. This is comparable to the literature reviewed that identified novices engaging in peer support practices independently or through web-based forums accessed these less and were perceived as less valuable than peer support facilitated face-to-face within transition programmes (Banks et al., 2011; Solowiej et al., 2010). Therefore, employers and educators should never overlook the importance of facilitating and building strong peer support networks between novices during transition. In conjunction with research, this study provides rationale for peer support processes to be formally mandated and facilitated within transition programmes, alongside other professional supports such as preceptorship and pastoral care, as these are all crucial elements that create a protected space for novice allied health practitioners during transition.

Transition Programmes Value Novice Practitioners as 'Novices'

Finally, the findings reiterated the importance of viewing and valuing the novice practitioner as a 'novice'. Participants in this study progressed through distinct transitional stages and had specific professional development needs at each of these stages, as novices. The findings showed participants perceived the transition as overwhelming and experienced stress, specific to novices, which negatively impacted their wellbeing during transition.

Novice Transition Stages

Study participants detailed the excitement and anxieties of entering practice; feeling unprepared and having expectations of practice that were not met; gradually developing competence and confidence; and, finally, adjusting to the realities of practice. Novices progressing through a series of stages and their evolving professional development during transition is well documented in literature regarding novice transition experiences within both nursing and allied health disciplines (Beddoe et al., 2018; Duchscher, 2009; Glassburn, 2020; Murray et al., 2019; Tryssenaar & Perkins, 2001). The findings of this study affirm previous research and theory of the developmental approach to novice transitions and the understanding that novices gradually progress from 'beginners to experts' over time, once acquiring skills, knowledge and clinical practice experience (Glassburn, 2020; Murray et al., 2019; Tryssenaar & Perkins, 2001). Positioning the novice as a 'novice', understanding novice transition stages and critical points within should be considered essential knowledge for mental health sector employers and educators, to enable the provision of tailored supports and resources that recognise the unique experiences of novices, as novices, at each of these developmental stages. Integrating theoretical transition frameworks, such as that of Murray et al.'s (2019) developmental perspective, within future transition programme design and

delivery could therefore be useful as an additional scaffold to guide understanding novice transitions and effectively meeting novices needs during each transition stage.

It is Ok to Feel Overwhelmed

Participants described the transition to practice as novices as transformative, challenging, and significant; an experience named in this study as *Making the Big Leap*. The concept of transitions being perceived as a 'big leap' is not new. Earlier studies (Lee & Mackenzie, 2003; Seah et al., 2011) and recent contemporary research from Australia, determined that novice allied health practitioners continue to experience the transition to practice as stressful, profound and "overwhelming" (Turpin et al., 2021, p. 14). Participants attributed experiencing the transition as overwhelming, in part, due to being new (McCombie & Antanavage, 2017) and, as one participant, aptly summarised, novices "*having to learn everything*" (Frankie) during transition. Feeling overwhelmed with no resolution during transition has been highlighted by previous research as a significant determinant of novices having negative transition experiences (Lee & Mackenzie, 2003) and decreased job satisfaction (Glassburn, 2020; Sutton & Griffin, 2000)—factors closely linked to the attrition of novices from healthcare practice (Beddoe et al., 2018; Lloyd et al., 2007; Quick et al., 2007).

Well-known factors, specific to novices, contributed to study participants feeling overwhelmed during transition that are in keeping with transition research. Participants described feeling overwhelmed due to adjusting to working full-time (Smith & Pilling, 2007); carrying responsibility for consumer care (Morrison & Robertson, 2015; Murray et al., 2015; Robertson & Griffiths, 2009); managing high and complex caseloads (Moriarty et al., 2011; Toal-Sullivan, 2006); feeling unprepared for practice by their undergraduate training (Atkinson & Steward, 1997; Gray et al., 2012; Tryssenaar & Perkins, 2001); lacking confidence and competence (Doherty et al., 2009; Morrison & Robertson, 2015; Robertson & Griffiths, 2009; Sutton & Griffin, 2000); establishing professional identity (Lee & MacKenzie, 2003; Moorhead, 2019; Toal-Sullivan, 2006); and having limited technical skills and knowledge for specialist practice (Hodgetts et al., 2007; Lloyd et al., 2002; Moriarty et al., 2011; Toal-Sullivan, 2006).

Participants in this study reported feeling overwhelmed due to balancing transition programme workloads, academic commitments, clinical practice demands, and having limited time within workplace commitments to complete transition programme requirements. This is consistent with previous research reporting high stress levels were more prevalent for novices completing formal transition programmes with financial incentives (Erol et al., 2016; Morley, 2009b; Solowiej et al., 2010) or postgraduate academic components (Te Pou o te Whakaaro

Nui, 2017b, 2018a), in comparison to more informal transition programmes based on peer support (Liddiard et al., 2017) or supervisory support practices alone (Fitzgerald et al., 2015).

While evaluations of transition programmes have established these are effective vehicles to support novices' successful transition to practice (Rush, Adamack, Gordon, Lilly, & Janke, 2013; Rush et al., 2019); from a wider sector perspective, the findings suggest the need to better understand and meet the complex and unique needs of novices during transition, particularly novices undertaking formal transition programmes. Within Australia, the need to more comprehensively support novice transitions has been recognised and addressed through national strategy designed to enhance the transition experiences and competence of novices through improved supervision practices (Health Workforce Australia, 2011). Initiatives such as building closer working relationships between programme providers, professional regulators, and clinical practice through targeted education, national strategy, and advocacy are potential solutions that would likely ameliorate the challenges and stress of novice transitions; initiatives that could be furthered within Aotearoa New Zealand.

Novice Wellbeing

Another finding highlighting the need to recognise and value novices as novices was that participants in this study struggled to maintain wellbeing and self-care when navigating the complexities and demands of transition. Given the literature argues that novices experience transitions as overwhelming (Turpin et al., 2021) and recent graduates experience high levels of anxiety and stress when entering clinical practice (Pfeifer, Kranz & Scoggin, 2008), stressed, anxious novices that are not coping with the transition or have little professional supports, such as rural practitioners (Lee & MacKenzie, 2003), should be identified as being at risk of attrition from practice (Lloyd et al., 2007; Quick et al., 2007). Thus, maintaining novice wellbeing and self-care should be prioritised within both education and clinical practice as part of acknowledging and supporting novices during transition and for retaining practitioners in the workforce long term (Tryssenaar & Perkins, 2001).

Initiatives for improving novice wellbeing and coping with transition have been explored within research. Providing stress management and mindfulness interventions during undergraduate nurse training has been shown to reduce novice stress, anxiety, and support a successful transition to practice (Kang, Choi, & Ryu, 2009). Kinsella et al.'s (2020) recent scoping review identified several positive benefits of providing mindfulness interventions for allied health and social services undergraduates during transition. They concluded providing mindfulness training improved overall student wellbeing, assisted with managing academic stress, and facilitated students to be more present and empathetic with consumers during fieldwork

placements (Kinsella et al., 2020). Though not exploring the perspectives of novices undertaking transition programmes, this research, supported by the findings of this study, strongly indicates the need for greater emphasis on nurturing the wellbeing and stress management capabilities of novices within both undergraduate and postgraduate training as part of preparing novices for the workforce and supporting novices during transition (Kang et al., 2009; Kinsella et al., 2020).

Novice Transition Shock

Participants described realising their expectations of practice and their professional values conflicted with the reality of the clinical practice context and the workplace values they encountered as novices, for which they were not prepared. Participants' description of transition, and the associated stress they experienced when the practice reality set in, parallel the phenomenon of 'reality shock' identified in Kramer's (1974) landmark research examining novice nurses' transition to clinical practice. Novice transition research has identified transition shock resolves for novices with adequate professional guidance, support (McCombie & Antanavage, 2017), and peer support (Smith & Pilling, 2007); while O'Shea and Kelly (2007) considered transition shock only lasted for the first five months of practice. Conversely, participants in this study who were interns described re-experiencing reality shock when moving to a second clinical role halfway through the transition programme and felt like they were starting out all over again. This was despite already having made the initial transition to clinical practice and having gained valuable professional experience; a finding also reported by Ankers et al. (2018) and Missen, McKenna, and Beauchamp (2016) for nursing graduates employed in intern rotation posts during transition. Thus, while the findings of this study, support a developmental approach to novice transitions, it also extends current conceptual understandings and affirms previous research that found novices changing clinical roles or employed in rotational posts during the transition period can re-experience transition shock and may regress in their professional development trajectory (Ankers et al., 2018; Missen et al., 2016). This suggests employers should have realistic expectations of novice practitioners and an awareness that novices may require additional, or adapted supports, more commensurate with a previous developmental stage, when changing clinical roles or when re-experiencing reality shock during the transition period. This finding implies increased attention is needed for reducing novice transition shock and consideration should be extended to novice interns rotating to new clinical settings, due to the reoccurrence of transition shock at this time. Furthermore, educating novices on transition stages and transition shock through workshops provided in the final year of undergraduate training, workplace orientation processes, and within transition programme curriculum, would likely enhance novices'

understanding of transition challenges and better prepare them for practice (Tryssenaar & Perkins, 2001). Therefore, taken together, the findings, in conjunction with literature, point to a potential role for undergraduate institutions and transition programme providers raising employers' awareness of novice transition stages, what types of support novices need and when it is needed, in order to ease known transition stressors unique to novices during transition.

Transition Programmes Advance Recovery-Oriented Practice

Participating in a transition programme with a strong recovery focus advanced participants' knowledge and application of recovery-oriented principles in practice. Having the voices of lived experience represented within the transition programme gave participants insights into consumer need and priorities. Hearing consumer narratives of recovery was a strong motivator for participants' continued efforts to integrate recovery principles within their practice, despite encountering barriers to doing so within current mental health service delivery.

Developing Recovery Knowledge

The findings showed participants' recovery knowledge was advanced through transition programme content focused on recovery principles, values, and recovery-oriented service delivery. Providing recovery-oriented care is considered fundamental to supporting mental health consumers in their personal recovery journeys (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Le Boutillier et al., 2015; Slade, 2009; Tondora, Miller, Slade, & Davidson, 2014). Transition programmes progressing the recovery knowledge of novice allied health practitioners supports the perspectives of Cusack, Killoury, and Nugent (2017), Le Boutillier et al. (2015), and Carpenter (2002) who have argued mental health practitioners must be educated to develop their recovery practices and provide quality, person-centred care for mental health consumers.

Participants described embracing contemporary recovery perspectives in their practice as these resonated with their professional values and personal beliefs regarding consumer care. Parallels between recovery and the philosophical and theoretical foundations of occupational therapy (Lloyd, Tse, & Bassett, 2004; Nugent, Hancock, & Honey, 2017) and social work (Carpenter, 2002; Khoury & Rodriguez del Barrio, 2015; Slade, 2009; Webber & Joubert, 2015) are well established. This is reflected in the position statements and scopes of practice of both these professions in Aotearoa New Zealand which articulate practitioners providing recovery focused care are disciplinary expectations of 'best practice' within mental health and addiction services (Occupational Therapy Board of New Zealand, 2021; Social Workers Registration Board, n.d.). Despite these parallels, research has shown progressing recovery in mental health

practice has been hampered by mental health clinicians' lack of understanding of recovery (Byrne, Happell, & Reid-Searl, 2015) or how to apply these principles in practice (Webber & Joubert, 2015).

Participants in the current study described being unaware of recovery perspectives prior to being introduced to these within the transition programme. This finding is concerning given the recovery paradigm in mental health is not new (Field & Reed, 2016; O'Hagan, Reynolds, & Smith, 2012) and integrating recovery-oriented values and increased consumer involvement within mental health practice has been amalgamated within government policy in Aotearoa New Zealand since 1998 (Mental Health Commission, 1998, 2012; O'Hagan et al., 2012).

There are examples provided in the literature of initiatives that have progressed recovery ideals within mental health such as having a shared recovery vision (Davidson & White, 2007; Slade, Adams, & O'Hagan, 2012); conceptual recovery frameworks (Leamy et al., 2011; Onken, Craig, Ridgway, Ralph, & Cook, 2007); recovery-oriented practice models (Frost et al., 2017; Randal et al., 2009); consumer and peer initiatives (Nelson et al., 2007; Repper & Carter, 2011); and evidence based recovery interventions and research (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008; Salyers & Tsemberis, 2007; Slade et al., 2014; Smith-Merry, Freeman, & Sturdy, 2011). However, aligning with existing literature (Carpenter, 2002; Cusack et al., 2017; Le Boutillier et al., 2015) the findings of this study signal a continued need for developing practitioners' recovery knowledge within education to advance recovery practices within mental health services in Aotearoa New Zealand. The findings indicate the potential for postgraduate transition programmes based on core recovery principles as being a vehicle well positioned to achieve this aim, which further longitudinal research could establish.

Hearing the Voice of Lived Experience

Participants' recovery knowledge was furthered through consumers with lived experience presenting transition programme teaching sessions, hearing consumer narratives, and the recovery journeys of guest speakers. Participants described transition programme content presented by consumers with lived experience as the most profound and meaningful learning gained from the transition programme. It extended participants' knowledge of mental distress at a deeper embodied level, beyond a theoretical understanding. Moreover, it facilitated participants' insights into the consumer perspective, emphasised it was critical to acknowledge consumers journeys, and motivated participants to cement recovery values within their professional practice. This finding supports previous research in social work (Beresford & Boxall, 2012; Duffy, Das, & Davidson, 2013) and nursing (Happell, Byrne, Platania-Phung et al., 2014; Happell & Roper, 2003), that have found consumer participation in tertiary education

programmes facilitated better understanding of consumers, reduced stigma, and challenged negative views of consumers held by healthcare students. Classen, Tudor, Johnson, and McKenna's (2021) recent integrative review of consumer involvement in tertiary education and research, further determined having consumers with lived experience teaching within healthcare education better prepared undergraduates for fieldwork and facilitated novices application of person-centred frameworks once employed in practice (Classen et al., 2021).

Study participants' identified having lived experience experts presenting transition programme content was critical as it provided exposure to consumers who were well. This was closely linked to participants' descriptions of '*having hope'*, a concept central to recovery and effective mental health practice (Russinova, 1999; Slade, 2009). Hearing positive consumer narratives of recovery was vital for showing participants that consumers can, and do, recover and lead meaningful lives despite the presence of serious mental illness; a finding which has widespread consensus in the literature (Anthony, 1993; Byrne, Happell, & Reid-Searl, 2016; Carpenter, 2002; Ridley, Martin, & Mahboub, 2017; Slade, 2009).

Maintaining hope was essential for participants practicing in inpatient or restrictive settings or those working with consumers experiencing acute distress or symptoms of mental illness; which previous research supports (McKenna et al., 2014; Schmulian, Redgen, & Fleming, 2020; Sorenson, Bolick, Wright, & Hamilton, 2016). Hopeful practitioners believing in the possibility of recovery are more able to provide person-centred and optimistic interventions that lead to improved consumer outcomes (Slade & Longden, 2015; Spandler & Stickley, 2011). Conversely, clinicians only seeing consumers who are unwell can lead to depersonalisation of consumers (Bakker & Heuven, 2006; Bride, Radey, & Figley, 2007; Figley, 1995; Mathieu, 2007; Thomas, 2013), or having lowered expectations of consumer abilities and their potential for recovery (Byrne, Happell, & Platania-Phung, 2015; Peris, Teachman, & Nocek, 2008).

Undergraduate fieldwork placements provide opportunities for students to have exposure to mental health consumers experiencing varying degrees of wellness prior to entering clinical practice (Gonczi, 2013; Repper & Breeze, 2007). Contemporary placement projects have been developed within nursing designed to foster positive clinician perspectives of mental health consumers during undergraduate training. 'Recovery camp' initiatives involve students, consumers, and academic staff spending five days together in a recreation-based camp and engaging in a range of social and physical activities (Moxham et al., 2016). Research examining 'recovery camps' found several positive outcomes of students learning directly from consumers with lived experience that included increased understanding of the personalised nature of recovery, awareness of stigma, and enhanced practice knowledge and skills (Moxham et al., 2016; Patterson et al., 2016). Although requiring future research, initial

findings suggest a potential role for recovery-based placements in advancing the recovery knowledge and empathy of undergraduate students towards mental health consumers that could ultimately result in novice practitioners '*having hope*' when entering mental health and addiction practice.

It was concerning that participants in this study reported not having any consumers with lived mental health experience teaching within their undergraduate training. To some extent, this reflects the findings of Happell, Byrne, McAllister, et al.'s (2014) systematic review that identified consumer involvement in healthcare education varied significantly between tertiary institutions and healthcare programmes or was, at worst, tokenistic. Genuine consumer involvement at all levels of service development and delivery is mandated within national policy and mental health strategy in Aotearoa New Zealand (Health Quality & Safety Commission 2015; Minister of Health, 2016). However, the findings of this study indicate consumer involvement across all levels of healthcare education in Aotearoa New Zealand would likely benefit from significant review.

Solutions for progressing meaningful consumer involvement within mental health nursing education have emerged from the co-production research space including the generation of international standards for integrating lived experience experts within academia and developing mental health teaching modules, based on recovery principles and standards, to be delivered within healthcare education (Horgan et al., 2020). Preliminary research applying these modules within nursing education provides some evidence of the value meaningful consumer-led education in mental health can offer, including more positive student attitudes towards consumers (Happell, Platania-Phung, et al., 2019), understanding the unique individual 'behind the diagnosis', and encouraging students to integrate recovery perspectives within their mental health practice (Happell, Waks, et al., 2019). Introducing initiatives such as these within professional healthcare education in Aotearoa New Zealand is likely achievable; however, would require action from key mental health stakeholders, academia, and lived experience experts and researchers, that could be strengthened through building education strategy and policy.

Barriers to Advancing Recovery-Oriented Practice

As detailed in the finding, *Fighting the Old Ways*, participants encountered several challenges during transition to practice; in particular, barriers to applying recovery ideals within the clinical practice context and recognising that recovery has not yet been fully integrated within mental health service delivery, despite current discourse within both education and mental health sectors in Aotearoa New Zealand deeming recovery as 'best practice' (Mental Health

Foundation, 2020; New Zealand Government, 2018; Slade, 2009). The ideological conflict identified by study participants revealed a dichotomy between the reality of specialist mental health practice—one predominantly driven by a biomedical approach towards mental distress, and the practice ideal presented within transition programmes—providing person-centred recovery-oriented care. This tension is widely acknowledged in the literature (Chen, Krupa, Lysaght, McCay, & Piat, 2013; Dalum, Pedersen, Cunningham, & Eplov, 2015; Davidson & White, 2007; Hummelvoll, Karlsson, & Borg, 2015; Pack, 2010), and supports national policy (Mental Health Commission, 2007), recovery literature (Field & Reed, 2016; Gawith & Abrams, 2006; O'Hagan et al., 2012), and the findings of the recent mental health and addiction inquiry (New Zealand Government, 2018), which have clearly stated mental health and addiction services are falling short in terms of adopting recovery ideals in clinical practice and the care of consumers.

Participants' experiences of the ideological conflict during transition are reflective of Slade, et al.'s (2012) editorial article, *'Recovery: Past progress and future challenges',* which highlighted mental health systems internationally are undergoing a transformational paradigm shift. Slade et al. (2012) contended that while the mental health sector has adopted recovery rhetoric, clinical practice has not yet sufficiently changed or become aligned with current policy, consumer need, and recovery discourse. As participants in the current study detailed, this incongruence creates significant dissonance for novices completing recovery-oriented transition programmes and when trying to apply recovery perspectives in this context, potentially further amplifying feelings of discontent or transition shock and negatively impacting novices' resilience to 'keep the faith' or remain positive about practicing in mental health and addiction practice altogether.

Being exposed to recovery-oriented perspectives within transition programmes supported participants to resist fully capitulating to outdated paradigms of deficit-based approaches to consumer care (Carpenter, 2002; Chen et al., 2013). Even in the face of active resistance, participants found ways of integrating recovery into individual work with consumers. Consistent with literature, participants' continued efforts were strengthened through garnering support from colleagues and peers with similar ideals and examples provided by recovery leaders like transition programme staff, supervisors, or recovery champions in the workplace (Byrne et al., 2016; Chang, Chang, Hsu, & Huang, 2021; Nugent et al., 2017), However, changes at a micro level are not enough to drive fundamental system transformation and improve the genuine uptake of recovery in mental health practice.

The findings of this study align with the current call to action to transform mental health and addiction services in Aotearoa New Zealand and suggest that while there is a requirement

within academia to develop and advance contemporary approaches to practice, the mental health sector equally needs to be accepting of integrating recovery and person-centred perspectives within current service delivery. The current study indicates the need for significant change within both tertiary education and clinical practice to reduce this divide, improve the transition experiences of novices, and advance recovery-oriented practice in Aotearoa New Zealand. For education and transition programme providers, this points to an obligation to better link to the clinical practice context and develop stronger working relationships with mental health providers as part of better supporting novice allied health practitioners during transition while these systemic changes take place.

Establishing stronger partnerships between education and clinical practice would ensure novices are entering practice contexts receptive of research and recovery-oriented practices being taught within academia (De Geest et al., 2013; Gonczi, 2013; Happell, 2009). Nursing research provides examples of successful collaborative partnership initiatives that have successfully offset this disconnect between clinical practice and academia that have proved beneficial for both sectors (Harris, Jones, & Coutts, 2010; McLachlan et al., 2017). Strategies for progressing partnership models have included developing formal agreements delineating each sector's roles and responsibilities (Downie et al., 2001), having a shared purpose, employing staff in dual roles straddling both academic and clinical workspaces (Garland, Plemmons & Koontz, 2006), and creating research posts to promote practice-driven research to further understanding of best practice outcomes (Davies, Turner, & Osborne, 1999). Such partnerships have resulted in a more seamless integration of educational research and innovations within practice and have supported widespread understanding and acceptance of recovery best practice within both sectors (De Geest et al., 2013; Downie et al., 2001; Happell, 2009). Collaborative practice models focused on developing recovery-oriented care should be established through formal partnerships and contractual agreements between employers of novice practitioners' and healthcare education institutions, which could include transition programme providers.

From a wider sector perspective, the need for significant change has been signalled at many levels within mental health and addiction (Mental Health Commission, 1998, 2007; New Zealand Government, 2018) and is echoed by the findings of the current study. Change will require significant investment of resources and commitment from key stakeholders such as government, policy makers, tertiary education providers, professional regulators, and employers within mental health services (New Zealand Government, 2018). If achieved, this could have far-reaching benefits, including for novice practitioners completing transition

programmes bringing recovery knowledge to mental health and addictions practice. Changes are sorely needed to reinvigorate and progress recovery practices in Aotearoa New Zealand.

Contribution of Research

This study contributes new understandings to the literature about novice occupational therapy and social work practitioners' experiences of engaging in a specialist mental health and addiction transition to practice programme with a postgraduate academic component. It includes insights into transition programmes beings perceived as a protected space and advancing the recovery-oriented practice of novice allied health practitioners. The study findings also support current theoretical frameworks of a developmental approach to novice transitions. Furthermore, the findings extend conceptual understandings - and potentially adds to Murray et al.'s (2019) transition model - the knowledge that there may be additional periods of vulnerability during transition when novices may return to a prior developmental stage (for example, re-experiencing transition shock) and will require additional support and resources. The context for the research also offers a unique perspective and has generated novel knowledge about the experiences of novice allied health practitioners completing transition programmes within Aotearoa New Zealand.

Only a small number of purely qualitative explorations of the experiences of novice allied health practitioners completing transition to practice programmes have been published (Erol et al., 2016; Morley, 2009a). As discussed in the literature review (see Chapter Two), allied health transition programme research conducted specific to the mental health and addiction practice context is sparse; and prior to the current study, it had not been comprehensively explored. To my knowledge, at the time of completing this research, this is one of the few existing qualitative studies to access the subjective perspectives of novice allied health practitioners completing specialist transition to practice programmes in the mental health and addiction domain, both in Aotearoa New Zealand and internationally. Therefore, this study adds to the allied health disciplinary knowledge base and contributes a current Aotearoa New Zealand perspective to the limited qualitative research existing within this area.

Research Strengths

There were three key strengths of this study. Firstly, the intent of this study was to generate in-depth understandings of novice allied health practitioners' perceptions of completing a specialist transition to practice programme. Prior to this study, this was an area that had not be comprehensively examined by previous research, nor had there been an explicit focus on novice occupational therapy and social work practitioners within the available published transition programme literature. Exploring the subjective experiences of allied health

practitioners completing transition programmes in the Aotearoa New Zealand context has brought to light insights and knowledge missing from previous research that can progress future transition programme provision; aligning this study closely with the fundamental purpose of interpretive description methodology.

Secondly, purposive sampling ensured recruiting a diverse range of participants that is reflected in the varied demographic characteristics of participants in this study such as age, gender, ethnicity, cultural affiliations, professional roles, life experience, and practice contexts. The first focus group captured participants from a single urban centre, while the use of an online platform for the second focus group captured participants across Aotearoa New Zealand. Two participants were male and two were mature students. Given the low percentage of men in occupational therapy and social work professions, and the inclusion of mature students, this study captured two perspectives that were identified within the literature reviewed as often being omitted within research in these disciplines. This provides support and justification for the findings reached.

Thirdly, as this study took place in the Aotearoa New Zealand's bicultural context, acknowledging and including the voice of Māori is germane as part of upholding Te Tiriti o Waitangi principles within research. In reference to the principle of participation, discussed within ethical considerations, it was a strength that this Aotearoa New Zealand study included one participant who identified as Māori. There was also one Pasifika participant who identified as Fijian. This facilitated the inclusion of two voices that are often under-represented within health and social-sciences research and literature.

Research Limitations

There were five main study limitations that need to be considered alongside the research findings. Firstly, this small-scale study recruited nine participants who had completed the specialist mental health and addiction transition to practice programme in Aotearoa New Zealand which has implications for transferability or generalisation of the findings reached. While this study generated rich data reflective of participants' experiences of this particular programme, it is not anticipated that the experiences of these participants, or the findings reached, will be representative of the experiences of all other allied health novice practitioners participating in specialist mental health and addictions transition to practice programmes in Aotearoa New Zealand. Indeed, neither will it be representative of the experiences of allied health novice practitioners internationally, disciplines outside social work and occupational therapy, or novice practitioners transitioning to practice in specialist clinical areas outside of mental health and addiction. As such, findings and recommendations should not be considered

'the whole truth' or the only outcome that would be reached when exploring the experiences of all novice practitioners undertaking specialist transition to practice programmes. Rather, as intended, the findings should be regarded as presenting a "tentative truth claim" (Thorne et al., 2004, p. 4) about the commonalities and differences of participants' experiences who completed this particular mental health and addiction transition to practice programme.

Secondly, as this was a small exploratory study, the decision was made to access only the perceptions of participants who were the focus of the research—novice allied health practitioners. While this data source matched the intent of the study, the use of collateral sources of data could have been considered within the study design and methods (Thorne, 2008). This study could have also undertaken individual interviews with novice allied health practitioners or conducted a focus group or interviews with experienced clinicians who supervise, mentor, and manage novice practitioners participating in transition programmes to deepen the insights gained or enrich the themes and findings reached.

Thirdly, the significant period of time (i.e. five months) that elapsed between focus group interviews during data collection may have impacted participant recall and, as a result, the trustworthiness of the findings of this study. While Thorne (2006) recommends having significant gaps between focus groups to allow for prolonged engagement with the data, this extended delay meant participants in focus group two were not as 'close' to their transition programme experiences, the phenomena of interest. These participants' reflections on their experiences of the programme may therefore not be as accurate, or detailed, as they could have been if the second focus group had been conducted earlier.

Fourthly, given this research was conducted in the bicultural context of Aotearoa New Zealand, and the growing awareness of the need for healthcare practitioners reflective of the consumers utilising mental health and addiction services, there could have been greater emphasis placed on exploration specific to the experiences of Māori novice practitioners undertaking mental health and addiction transition programmes. Although the inclusion of one Māori participant in the study is considered a strength, this was not focused on to the degree it could have been, in part, due to the study being constrained by the timeframe, scope, and financial restrictions of a Master's level thesis. Nevertheless, an opportunity could have been created to undertake an individual interview with this participant within the research design, or to purposively sample Māori novice allied health practitioners and conduct a hui or wānanga to capture the experiences of these clinicians that they may not have felt safe to share within the mechanisms used to gather data in this study. This would add significantly to understanding the specific needs of Māori allied health practitioners undertaking mental health and addiction transition to practice programmes in Aotearoa New Zealand and would

more closely align the research with mental health sector priorities and bicultural Tiriti o Waitangi obligations.

The fifth limitation relates to the lack of inclusion of rural participants or participants occupying more isolated allied health sole-practitioner roles, as most participants recruited were practicing in urban, metropolitan cities. These are practitioners who may have had a significantly different experience of the transition programme because of differing levels of support, such as access to mentorship and supervision. Accommodations to access these voices through the ZOOM online conferencing platform and potentially undertaking a third focus group for practitioners in these areas could have been pursued. This suggests a further consideration for ongoing research and investigation.

Recommendations

While most findings of this study expanded or confirmed existing literature, there are several key recommendations, drawn from the study findings, that could be implemented within the practice-education space and mental health sectors to progress workforce development, transition programme provision and the transition to practice experiences of allied health practitioners. These recommendations include:

Healthcare Education:

- A priority for undergraduate healthcare programmes should be to integrate further mental health knowledge, theory and practice frameworks (e.g. *Let's get real*) within allied health curriculum to better prepare graduates for mental health and addiction practice. This should include core mental health clinical intervention skills like talking therapies, goal setting, sensory modulation, managing distress, mental health assessment and intervention tools.
- Undergraduate healthcare programmes need to provide opportunities for the practical application of theoretical mental health knowledge in context, to develop graduate confidence and competence prior to entering the workforce. This should include mental health and addiction fieldwork placements or simulation-based learning and roleplay.
- Healthcare education programmes should prioritise recovery-oriented practice principles and values, person-centred care and theoretical recovery frameworks as essential curriculum in Aotearoa New Zealand. Furthermore, employers must develop supportive workplace cultures that value novices and are accepting of the recovery-oriented values they bring to practice.

- Undergraduate programmes need to provide graduates with exposure to mental health consumers experiencing varying degrees of wellness to better prepare graduates entering the mental health workforce. Having lived experience experts employed in teaching roles as integral members of healthcare programmes, fieldwork placements and 'Recovery camps' could provide this.
- Healthcare education programmes should provide education focused on the stages of novice transitions and critical points within these, including transition shock, to both graduates and employers of graduates. Theoretical transition frameworks (e.g. Murray et al., 2019) could scaffold such education and include supports, practical strategies and resources graduates require at each transition stage, including the needs of graduates in internships or rotational posts.
- Strategies for managing self-care, well-being, reducing stress and increasing practitioner resilience (e.g. mindfulness) during the transition should be integrated as fundamental components of all healthcare curriculum.

Transition Programmes:

- Transition programme content needs to be based on adult learning principles to progress novice knowledge and skills and support a successful transition to mental health practice. Teaching methods should be scaffolded and timely and include direct teaching of theory and principles, study days, group-based learning and supervision, applied case studies, and flexible assessment processes adaptable to varied practice contexts.
- Transition programmes should provide programme/academic support, guidance and pastoral care for novices, independent of workplace support practices.
- Facilitating peer support groups for novices to build strong peer support networks during transition should be an integral part of transition programmes and clinical practice. This should occur face-to face, where possible.
- Transition programme entry should be inter-disciplinary in nature and representative of all professions working across mental health and addiction services in Aotearoa New Zealand to progress quality consumer care and interdisciplinary working in practice. Opportunities for discipline-specific, interdisciplinary networking and knowledge sharing to support novices' acquisition of professional identity during transition should be facilitated.
- Transition programmes need to engage organisational support from employers of novices undertaking transition programmes in Aotearoa New Zealand. Requirements should be clearly stipulated and mandated through formal agreement, prior to

transition programme commencement. Agreements should include, but not be limited to, employers committing to releasing novices to attend teaching blocks, study days, maintaining reduced caseloads, providing additional supervision, and workplace preceptors.

- Transition programme providers have an obligation to better link to the clinical practice context and develop stronger working relationships with mental health providers nationally as part of better supporting novice allied health practitioners entering the workforce.

Wider Sector:

- Developing a preceptorship community of practice for in Aotearoa New Zealand should be explored given preceptorship is essential for supporting and progressing novice competence during transition. A practice-education community of practice is needed to advance preceptorship quality, develop training, preceptor support networks and standardised preceptorship practices. Funding for preceptorship practices should be investigated.
- Lived experience experts need to be meaningfully involved within the design and delivery of mental health curriculum, and the research underpinning this. This could be progressed through co-design and co-production. Consumer involvement across all levels of healthcare education and mental health service delivery in Aotearoa New Zealand would benefit from significant review and could be strengthened through building education strategy and sector policy in this area.
- Collaborative practice models to advance recovery-oriented care in Aotearoa New Zealand should be established between employers and healthcare education through formal contractual agreements. This could be strengthened through action from mental health stakeholders (e.g. government, policy makers, tertiary education providers, professional regulators, consumers, employers), national strategy and policy

Future Research

As a result of this study, and as the discussion and limitations of the study have suggested, there are several areas that would benefit from further research. Recommendations for ongoing research include conducting a larger study exploring the experiences of novice allied health practitioners completing specialist mental health and addictions transition to practice programmes, including programmes with a postgraduate academic component, as this would enable findings to be compared and contrasted. It would also allow a more comprehensive

consideration of the benefits and enablers of mental health and addictions transition to practice programmes and a detailed examination over time as to how they facilitate the transition to practice of novice allied health practitioners. Future research should consider exploring the perspectives of experts, team leaders, and clinicians who support novice practitioners participating in transition programmes to enrich disciplinary understandings as this study did not integrate these perspectives within the research design.

This study explored the perspectives of novice allied health practitioners who successfully completed a specialist mental health and addiction transition to practice programme. What it did not explore were the experiences of novice practitioners who withdrew and were not able to complete the transition programme. This is an avenue for future research that could provide novel and meaningful insights into additional challenges and barriers novice allied health practitioners face when undertaking transition programmes; currently this does not appear to have been fully examined by research. Exploring factors that impede or negatively impact the successful completion of transition programmes would enhance understanding of additional learning and support needs of novice allied health practitioners undertaking transition programmes and areas of the programme itself that may require future scrutiny and change. Future longitudinal research could also determine the role that transition to practice programmes play in the retention of novice allied health practitioners in the mental health and addiction sector.

Limitations identified in this study could be addressed by future qualitative research that explores the perspectives of the participants omitted from this study, such as rural participants or participants occupying more isolated roles, who may have reduced access to professional support when engaging in transition programmes. Furthermore, this study did not explicitly focus on the ethnicity of participants. Future research that specifically explores the perspectives of Māori novice allied health practitioners completing transition programmes is needed to contribute to addressing Māori health inequities and ensure building the Māori workforce capacity alongside developing a workforce reflective of consumers accessing mental health and addictions services in Aotearoa New Zealand. Exploring the perspectives of Māori clinicians and clinicians from other ethnic groups, would contribute understandings to ensure future transition programme provision is tailored to meet the needs of practitioners from a diverse range of ethnicities, particularly minority ethnicities, in the Aotearoa New Zealand context. This would add to the perspectives gained from practitioners in the current study, and align ongoing research more closely with national policy and mental health and addiction sector priorities.

Future research extending the findings of this study through exploring personality characteristics or personal and contextual factors that influence novice allied health practitioners' successful completion of mental health and addictions transition to practice programmes would have significant value. This would advance disciplinary understandings and highlight those novice practitioners requiring additional support, as well as facilitating development of more targeted assistance and interventions within transition programmes to more effectively meet the individual needs of novice practitioners.

Finally, research based on theoretical models of transition have been conducted in the nursing discipline (Murray et al., 2019), and have been shown to provide effective frameworks to investigate and measure phenomena commonly occurring during the transition to practice (e.g., transition shock, adaptation to practice). Replicating these research methods and conducting studies based on allied health transition models could provide further insights into the experiences of novice allied health practitioners engaging in specialist mental health and addictions transition to practice programmes. This understanding would aid developing resources and mechanisms to reduce the impact of common challenges experienced by novice allied health practitioners during the transition. This would facilitate a more positive and successful transition experience but may also contribute to retaining novice allied health practitioners in their respective professions, and within mental health and addiction practice in the longer term.

Conclusion

This interpretive description study aimed to discover novice allied health practitioners' perceptions of engaging in a specialist mental health and addiction transition to practice programme to further disciplinary understandings as to how the transition programme supported participants' transition to practice in Aotearoa New Zealand. The findings revealed that novice allied health practitioners' experienced the evolution to professional practice as 'making a big leap', even when engaged in, and supported by, a transition to practice programme designed to ease the challenges of the transition period. While novice allied health practitioners derived a sense of feeling protected and held from participating in a specialist transition programme, of equal significance was that novice allied health practitioners encountered significant tensions during transition, several of which were due to contextual and systemic challenges when bringing transition programme knowledge to the clinical practice arena, particularly recovery-oriented content.

Key outcomes of this research have determined that for the participants in this study, transition programmes supported transition, provided a protected space, recognised the

novice practitioner as a 'novice', and advanced recovery-oriented knowledge and practice of novices. Despite the limitations of conducting a small-scale exploratory study and the limited generalisability of the findings, honouring the perspectives of participants through the authentic representative of their experiences was a strength of this study. This research has contributed new knowledge and insights to the growing body of knowledge about transition to practice programmes by developing thematic understandings of novice allied health practitioners' perceptions of undertaking specialist mental health and addiction programmes with a postgraduate academic qualification. It has also added the unique voice of Aotearoa New Zealand novice allied health practitioners to existing literature and international research in this area.

In closing, a pressing concern for the mental health sector is that it requires significant evolution to put people first and embrace new and contemporary approaches to practice in order to provide care in a manner acceptable and responsive to consumers accessing mental health and addiction services. A call to action has been sounded by the recent inquiry into mental health and addiction in Aotearoa New Zealand—a call that needs to be answered. Enhanced intersectoral collaboration would ultimately provide significant benefits for novice allied health practitioners undertaking transition to practice programmes. This would create workplaces and practice environments more accepting of contemporary approaches to consumer care and more supportive of novice allied health practitioners applying these approaches in practice. Solutions to bring about changes, and to enhance clinical practice, have been proposed within this study, along with areas where further research may be warranted.

Finally, as the acuity and complexity of the needs of people accessing mental health services increases, so too does the need for a workforce of mental health clinicians capable and willing to meet these needs. As Robertson and Griffiths (2009) have so eloquently stated, novice allied health practitioners are the "lifeblood of the profession" (p. 126). Therefore, as the findings of the current study has shown, it is essential to comprehensively understand and meet the needs of novice allied health professionals participating in specialist mental health and addiction transition programmes for the future of mental health service delivery and for the betterment of mental health consumer care in Aotearoa New Zealand.

References

Acker, G. M. (2004). The effect of organizational conditions (role conflict, role ambiguity, opportunities for professional development, and social support) on job satisfaction and intention to leave among social workers in mental health care. *Community Mental Health Journal, 40*(1), 65-73. doi: 10.1023/B:COMH.0000015218.12111.26

Adamson, B. J., Hunt, A. E., Harris, L. M. & Hummel, J. (1998). Occupational therapists' perceptions of their undergraduate preparation for the workplace. *British Journal of Occupational Therapy, 61*(4), 173-179. doi: 10.1177/030802269806100411

Ankers, M, D., Barton, C. A., & Parry, Y. K. (2018). A phenomenological exploration of graduate nurse transition to professional practice within a transition to practice program. *Collegian, 25*(3), 319-325. doi: 10.1016/j.colegn.2017.09.002

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11-23. doi: 10.1037/h0095655

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using ZOOM videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods, 18,* 1-8. doi: 10.1177/1609406919874596

Atkinson, K., & Steward, B. (1997). A longitudinal study of occupational therapy new practitioners in their first sources of professional practice: Preliminary findings. *British Journal of Occupational Therapy, 60*(8), 338-342. doi: 10.1177/030802269706000802

Babatsikou, F., & Gerogianni, G. (2012). The importance of role play in nursing. *Health Science Journal, 6*(1), 4-10. https://www.researchgate.net/publication/289695264

Bakker, A. B., & Heuven, E. (2006). Emotional dissonance, burnout, and in-role performance among nurses and police officers. *International Journal of Stress Management, 13*(4), 423-440. doi: 10.1037/1072-5245.13.4.423

Ballantyne, N., Beddoe, L., Hay, K., Maidment, J., Walker, S., & Ngan, L. (2019). *Enhancing the readiness to practise of newly qualified social workers in Aotearoa New Zealand (Enhance R2R).* Ako Aotearoa. https://ako.ac.nz/knowledge-centre/enhancing-the-readiness-to-practise-of-newly-qualified-social-workers/report-on-phase-one-the-social-work-curriculum

Ballinger, C. (2006). Demonstrating rigour and quality? In L. Finlay & C. Ballinger (Eds.), *Qualitative research for allied health professionals: Challenging choices* (pp. 235-246). Chichester, UK: John Wiley & Sons.

Banks, P., Roxburgh, M., Kane, H., Lauder, W., Jones, M., Kydd, A. & Atkinson, J. (2011). Flying Start NHS: Easing the transition from student to registered health professional. *Journal of Clinical Nursing, 20*(23-24), 3567-3576. doi: 10.1111/j.1365-2702.2011.03796.x

Beddoe, L., Hay, K., Maidment, J., Ballantyne, N., & Walker, S. (2018). Readiness to practice social work in Aotearoa New Zealand: perceptions of students and educators. *Social Work Education, 37*(8), 955-967. doi: 10.1080/02615479.2018.1497152

Beresford, P., & Boxall, K. (2012). Service users, social work education and knowledge for social work practice. *Social Work Education, 31*(2), 155-167. doi: 10.1080/02615479.2012.644944

Bertero, C. (2015). Developing qualitative methods – or "same old wine in a new bottle". *International Journal of Qualitative Studies on Health and Well-being, 10,* 1-2. doi: 10.3402/qhw.v10.27679

Birken, M., Couch, E., & Morley, M. (2017). Barriers and facilitators of participation in intervention research by mental health occupational therapists. *British Journal of Occupational Therapy, 80*(9), 568-572. doi: 10.1177/0308022617709184

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Braun, V., Clarke, V., & Gray, D. (2017). Innovations in qualitative methods. In B. Gough (Ed.), *The Palgrave handbook of critical social psychology* (pp. 243-266). London, UK: Palgrave Macmillan.

Bride, B. E., Radey, M. & Figley, C. R. (2007), Measuring compassion fatigue. *Clinical Social Work Journal, 35*(3), 155-163. doi: 10.1007/s10615-007-0091-7

Brown, J. E. (2019). Graduate nurses' perception of the effect of simulation on reducing the theory-practice gap. *SAGE Open Nursing, 5*, 2377960819896963. doi: 10.1177/2377960819896963

Bruce, R., Levett-Jones, T., & Courtney-Pratt, H. (2019). Transfer of learning from university-based simulation experiences to nursing students' future clinical practice: An exploratory study. *Clinical Simulation in Nursing, 35*, 17-24. doi: 10.1016/j.ecns.2019.06.003

Byrne, L., Happell, B., & Platania-Phung, C. (2015). Attitudes of nursing students on consumer participation: The effectiveness of the mental health consumer participation questionnaire. *Perspectives in Psychiatric Care, 51*(1), 45-51. doi: 10.1111/ppc.12064

Byrne, L., Happell, B., & Reid-Searl, K. (2015). Recovery as a lived experience discipline: A grounded theory study. *Issues in Mental Health Nursing, 36*(12), 935-943. doi: 10.3109/01612840.2015.1076548

Byrne, L., Happell, B., & Reid-Searl, K. (2016). Lived experience practitioners and the medical model: World's colliding? *Journal of Mental Health, 25*(3), 217-223. doi: 10.3109/09638237.2015.1101428

Casey, K., Fink, R. R., Krugman, A. M., & Propst, F. J. (2004). The graduate nurse experience. *Journal of Nursing Administration, 34*(6), 303-311. Retrieved from https://journals.lww.com/jonajournal/Fulltext/2004/06000/The_Graduate_Nurse_Experience.10.aspx

Carpenter, J. (2002). Mental health recovery paradigm: Implications for social work. *Health & Social Work, 27*(2), 86. doi: 10.1093/hsw/27.2.86

Chang, Y. C., Chang, L. H., Hsu, S. T., & Huang, M. W. (2021). Professional perspectives on providing recovery-oriented services in Taiwan: A qualitative study. *BMC Psychiatry, 21*(1), 154. doi: 10.1186/s12888-021-03152-y

Cheetham, G., & Chivers, G. (2001). How professionals learn in practice: An investigation of informal learning amongst people working in professions. *Journal of European Industrial Training, 25*(5), 247-292. doi: 10.1108/03090590110395870

Chen, S. P., Krupa, T., Lysaght, R., McCay, E., & Piat, M. (2013). The development of recovery competencies for in-patient mental health providers working with people with serious mental Illness. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(2), 96-116. doi: 10.1007/s10488-011-0380-x

Classen, B., Tudor, K., Johnson, F., & McKenna, B. (2021). Embedding lived experience expertise across the mental health tertiary education sector: An integrative review in the context of Aotearoa New Zealand. *Journal of Psychiatric and Mental Health Nursing, 28*(6), 1140-1152. doi: 10.1111/jpm.12756

Collins, J. (2004). Education techniques for lifelong learning. *RadioGraphics, 24*(5), 1483-1489. doi: 10.1148/rg.245045020

Crane, J., & Abbott, M. (2021). Mind the gap: The relationship between liminality, learning and leaving in pre-registration nurse education. *Nurse Education in Practice, 50,* 021952. doi: 10.1016/j.nepr.2020.102952

Critical Appraisal Skills Programme. (2018). *CASP qualitative checklist.* Retrieved January 20, 2019 from https://casp-uk.b-cdn.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Thousand Oaks, CA: Sage.

Curtin, M., & Fossey, E. (2007). Appraising the trustworthiness of qualitative studies: Guidelines for occupational therapists. *Australian Occupational Therapy Journal, 54*(2)*,* 88-94. doi: 10.1111/j.1440-1630.2007.00661.x

Cusack, E., Killoury, F., & Nugent, L. E. (2017). The professional psychiatric/mental health nurse: Skills, competencies and supports required to adopt recovery-orientated policy in practice. *Journal of Psychiatric and Mental Health Nursing, 24*(2-3), 93-104. doi: 10.1111/jpm.12347

Dalum, H. S., Pedersen, I. K., Cunningham, H., & Eplov, L. F. (2015). From recovery programs to recovery-oriented practice? A qualitative study of mental health professionals' experiences when facilitating a recovery-oriented rehabilitation programme. *Archives of Psychiatric Nursing, 29*(6), 419-425. doi: 10.1016/j.apnu.2015.06.013

Davidson, L., & White, W. (2007). The concept of recovery as an organizing principle for integrating mental health and addiction services. *The Journal of Behavioral Health Services & Research, 34*(2), 109-120. doi: 10.1007/s11414-007-9053-7

Davies, E., Tumer, C., & Osborne, Y. (1999). Evaluating a clinical partnership model for undergraduate nursing students. *Collegian, 6*(2), 23-40. doi: 10.1016/S1322-7696(08)60326-1

De Geest, S., Dobbels, F., Schönfeld, S., Duerinckx, N., Sveinbjarnardottir, E. K., & Denhaerynck, K. (2013). Academic service partnerships: What do we learn from around the globe? A systematic literature review. *Nursing Outlook, 61*(6), 447-457. doi: 10.1016/j.outlook.2013.02.001

Doherty, G., Stagnitti, K., & Schoo, A. M. M. (2009). From student to therapist: Follow up of a first cohort of Bachelor of Occupational Therapy students. *Australian Occupational Therapy Journal, 56*(5), 341–349. doi: 10.1111/j.1440-1630.2008.00751.x

Downie, J., Orb, A., Wynaden, D., McGowan, S., Zeeman, Z., & Ogilvie, S. (2001). A practice-research model for collaborative partnership. *Collegian, 8*(4), 27-32. doi: 10.1016/S1322-7696(08)60031-1

Duchscher, J. (2009). Transition shock: The initial stage of role adaptation for newly graduated Registered Nurses. *Journal of Advanced Nursing, 65*(5), 1103-1113. doi: 10.1111/j.1365-2648.2008.04898.x

Duffy, J., Das, C., & Davidson, G. (2013). Service user and carer involvement in role-plays to assess readiness for practice. *Social Work Education, 32*(1), 39-54. doi: 10.1080/02615479.2011.639066

Erol, R., Upton, P., & Upton, D. (2016). Supporting completion of an online continuing professional development programme for newly qualified practitioners: A qualitative evaluation. *Nurse Education Today*, *42,* 62-68. doi: 10.1016/j.nedt.2016.04.005. Epub 2016 Apr 27

Evans, C. A., & Kevern, P. (2015). Liminality in preregistration mental health nurse education: A review of the literature. *Nurse Education in Practice, 15*(1), 1-6. doi: 10.1016/j.nepr.2014.08.004

Faraz, A. (2016). Novice nurse practitioner workforce transition into primary care: A literature review. *Western Journal of Nursing Research, 38*(11), 1531-1545. doi: 10.1177/0193945916649587

Field, B. I., & Reed, K. (2016). The rise and fall of the mental health recovery model. *International Journal of Psychosocial Rehabilitation, 20*(2), 86-95.

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* (pp. 3-28). Baltimore, MD: The Sidran Press.

Fitzgerald, C., Moores, A., Coleman, A., & Fleming, J. (2015). Supporting new graduate professional development: A clinical learning framework. *Australian Occupational Therapy Journal*, *63*(1), 13-20. doi: 10.1111/1440-1630.12165

Frost, B. G., Tirupati, S., Johnston, S., Turrell, M., Lewin, T. J., Sly, K. A., & Conrad, A. M. (2017). An integrated recovery-oriented model (IRM) for mental health services: Evolution and challenges. *BMC Psychiatry, 17*(1), 22. doi: 10.1186/s12888-016-1164-3

Garland, A. F., Plemmons, D., & Koontz, L. (2006). Research–practice partnership in mental health: Lessons from participants. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(5), 517-528. doi: 10.1007/s10488-006-0062-2

Gawith, L., & Abrams, P. (2006). Long journey to recovery for Kiwi consumers: Recent developments in mental health policy and practice in New Zealand. *Australian Psychologist, 41*(2), 140-148. doi: 10.1080/00050060600657988

Glassburn, S. (2020). Where's the roadmap? The transition from student to professional for new Master of Social Work graduates. *Qualitative Social Work,* 19(1), 142-158. doi: 10.1177/1473325018807746

Gonczi, A. (2013). Competency-based approaches: Linking theory and practice in professional education with particular reference to health education. *Educational Philosophy and Theory, 45*(12), 1290-1306. doi: 10.1080/00131857.2013.763590

Grant, B. M., & Giddings, L. S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse, 13*(1)*,* 10-28. doi: 10.5172/conu.13.1.10

Gray, M., Clack, M., Penman, M., Smith, J., Bell, J., Thomas, Y. & Trevan-Hawke, J. (2012). New graduate occupational therapists feelings of preparedness for practice in Australia and Aotearoa/New Zealand. *Australian Occupational Therapy Journal, 59*(6), 445-455. doi: 10.1111/j.1440-1630.2012.01029.x

Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology, 42*(1), 135-144. doi: 10.1007/s10464-008-9180-1

Grimmer-Somers, K., Milanese, S., & Chipchase, L. (2011). *Research into best practices in e-Learning for allied health clinical education and training*. Brisbane, Australia: Clinical Education and Training Queensland.

Hammond, J., & Gibbons, P. (2005). Putting scaffolding to work: The contribution of scaffolding in articulating ESL education. *Prospect, 20*(1), 6-30. http://www.ameprc.mq.edu.au/__data/assets/pdf_file/0008/229760/20_1_1_Hammond.pdf

Happell, B. (2009). Influencing undergraduate nursing students' attitudes toward mental health nursing: Acknowledging the role of theory. *Issues in Mental Health Nursing, 30*(1), 39-46. doi: 10.1080/01612840802557113

Happell, B. (2015). A better way to do this? Views of mental health nursing directors about preparation for mental health nursing practice. *Australian Health Review, 39,* 211–216. doi: 10.1071/AH14099

Happell, B., Byrne, L., McAllister, M., Lampshire, D., Roper, C., Gaskin, C. J., … Hamer, H. (2014). Consumer involvement in the tertiary-level education of mental health professionals: A systematic review. *International Journal of Mental Health Nursing, 23*(1), 3-16. doi: 10.1111/inm.12021

Happell, B., Byrne, L., Platania-Phung, C., Harris, S., Bradshaw, J., & Davies, J. (2014). Lived-experience participation in nurse education: Reducing stigma and enhancing popularity. *International Journal of Mental Health Nursing, 23*(5), 427-434. doi: 10.1111/inm.12077

Happell, B., Platania-Phung, C., Scholz, B., Bocking, J., Horgan, A., Manning, F., … Biering, P. (2019). Changing attitudes: The impact of expert by experience involvement in mental health nursing education: An international survey study. *International Journal of Mental Health Nursing, 28*(2), 480-491. doi: 10.1111/inm.12551

Happell, B., & Roper, C. (2003). The role of a mental health consumer in the education of postgraduate psychiatric nursing students: the students' evaluation. *Journal of Psychiatric and Mental Health Nursing, 10*(3), 343-350. doi: 10.1046/j.1365-2850.2003.00599.x

Happell, B., Waks, S., Bocking, J., Horgan, A., Manning, F., Greaney, S., … Biering, P. (2019). 'There's more to a person than what's in front of you': Nursing students' experiences of consumer taught mental health education. *International Journal of Mental Health Nursing, 28*(4), 950-959. doi: 10.1111/inm.12596

Harper, L., & Ross, J. (2011). An application of Knowles' theories of adult education to an undergraduate interdisciplinary studies degree program. *The Journal of Continuing Higher Education, 59*(3), 161-166. doi: 10.1080/07377363.2011.614887

Harris, L., Jones, M., & Coutts, S. (2010). Partnerships and learning communities in work-integrated learning: designing a community services student placement program. *Higher Education Research & Development, 29*(5), 547-559. doi: 10.1080/07294360.2010.502288

Health Quality & Safety Commission. (2015). *Engaging with consumers: A guide for district health boards.* Wellington, New Zealand: Author.

Health Workforce Australia. (2011). *National clinical supervision support framework*. Author. www.hwa.gov.au/sites/uploads/hwa-national-clinical-supervision-support-framework-201110.pdf

Henderson, A., Ossenberg, C., & Tyler, S. (2015). 'What matters to graduates': An evaluation of a structured clinical support program for newly graduated nurses. *Nurse Education in Practice, 15,* 225-231. doi: 10.1016/j.nepr.2015.01.009

Hodgetts, S., Hollis, V., Triska, O., Dennis, S., Madhill, H. & Taylor, E. (2007). Occupational therapy students' and graduates' satisfaction with professional education and preparation for practice. *Canadian Journal of Occupational Therapy, 74*(3), 148-160. doi: 10.1177/000841740707400303

Hogan, S. (2021). *Hidden in plain sight: Optimising the allied health professions for better, more sustainable integrated care. New Zealand Institute of Economic Research report to Allied Health Aotearoa New Zealand (AHANZ)*. Retrieved from https://nzier.org.nz/publication/hidden-in-plain-sight-optimising-the-allied-health-professions-for-better-more-sustainable-integrated-care

Howlett, M. (2021). Looking at the 'field' through a Zoom lens: Methodological reflections on conducting online research during a global pandemic. *Qualitative Research,* 22(3), 1468794120985691. doi: 10.1177/1468794120985691

Holmes, J. D., Bossers, A. M., Polatajko, H. J., Drynan, D. P., Gallagher, M., O'Sullivan, C. M., … Denney, J. L. (2010). 1000 fieldwork hours: Analysis of multi-site evidence. *Canadian Journal of Occupational Therapy, 77*(3), 135-143. doi: 10.2182/cjot.2010.77.3.2

Horgan, A., Manning, F., Donovan, M. O., Doody, R., Savage, E., Bradley, S. K., … Happell, B. (2020). Expert by experience involvement in mental health nursing education: The co-production of standards between experts by experience and academics in mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 27*(5), 553-562. doi: 10.1111/jpm.12605

Hudson, M. L. & Russell, K. (2009). The Treaty of Waitangi and research ethics in Aotearoa. *Bioethical Inquiry, 6*, 61-68. doi: 10.1007/s11673-008-9127-0

Hummelvoll, J. K., Karlsson, B., & Borg, M. (2015). Recovery and person-centredness in mental health services: Roots of the concepts and implications for practice. *International Practice Development Journal, 5*(Suppl. 7). Retrieved December 1, 2021 from https://www.fons.org/Resources/Documents/Journal/Vol5Suppl/IPDJ_05(suppl)_07.pdf

Hunt, M. R. (2009). Strengths and challenges in the use of interpretive description: Reflections arising from a study of the moral experience of health professionals in humanitarian work. *Qualitative Health Research, 19*(9), 1284-1292. doi: 10.1177/1049732309344612

Hunt, S., Lowe, S., Smith, K., Kuruvila, A., & Webber-Dreadon, E. (2016). Transition to professional social work practice: The initial year. *Advances in Social Work & Welfare Education,* 18(1), 55-71.

Hurlock, D., Barlow, C., Phelan, A., Myrick, F., Sawa, R., & Rogers, G. (2008). Falls the shadow and the light: Liminality and natality in social work field education. *Teaching in Higher Education, 13*(3), 291-301. doi: 10.1080/13562510802045311

Jewel, A. (2013). Supporting the novice nurse to fly: A literature review. *Nurse Education in Practice, 13*(4)*,* 323-327. doi: 10.1016/j.nepr.2013.04.006

Kalet, A., Buckvar-Keltz, L., Harnik, V., Monson, V., Hubbard, S., Crowe, R., … Yingling, S. (2017). Measuring professional identity formation early in medical school. *Medical Teacher, 39*(3), 255-261. doi: 10.1080/0142159X.2017.1270437

Kang, Y. S., Choi, S. Y., & Ryu, E. (2009). The effectiveness of a stress coping program based on mindfulness meditation on the stress, anxiety, and depression experienced by nursing students in Korea. *Nurse Education Today, 29*(5), 538-543. doi: 10.1016/j.nedt.2008.12.003

Kelliher, F. (2005). Interpretivism and the pursuit of research legitimisation: An integrated approach to single case design. *Journal of Business Research Methods, 3*(2), 45-62.

Khoury, E., & Rodriguez del Barrio, L. (2015). Recovery-oriented mental health practice: A social work perspective. *The British Journal of Social Work, 45*(Suppl. 1), S27-S44. doi: 10.1093/bjsw/bcv092

Kidd, P. S., & Parshall, M. B. (2000). Getting the focus and the group: Enhancing rigor in focus group research. *Qualitative Health Research, 10*(3), 293-308. doi: 10.1177/104973200129118453

Kim, H., Sefcik, J. S., & Bradway, C. (2017). Characteristics of qualitative descriptive studies: A systematic review. *Research in Nursing & Health, 40*(1), 23-42. doi: 10.1002/nur.21768

Kinsella, E. A., Smith, K., Bhanji, S., Shepley, R., Modor, A., & Bertrim, A. (2020). Mindfulness in allied health and social care professional education: a scoping review. *Disability and Rehabilitation, 42*(2), 283-295. doi: 10.1080/09638288.2018.1496150

Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between participants. *Sociology of Health and Illness, 16*(1)*,* 130-121. doi: 10.1111/1467-9566.ep11347023

Knowles M., (1984). The adult learning theory - andragogy. Retrieved February 17, 2021, from https://elearningindustry.com/the-adult-learning-theory-andragogy-of-malcolm-knowles

Kramer, M. (1974). *Reality shock.* St Louis, MO: Mosby.

Krueger, R. A., & Casey, M.A. (2000). *Focus groups: A practical guide for applied research* (3rd ed.). Thousand Oaks, CA: Sage.

Kumaran, S., & Carney, M. (2014). Role transition from student nurse to staff nurse: Facilitating the transition period. *Nurse Education in Practice, 14*(6)*,* 605-611. doi: 10.1016/j.nepr.2014.06.002

Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge, UK: Cambridge University Press.

Layne, K., McGee, E., Frank, E., & Petrocelli, T. (2021). Simulation scaffolding in occupational therapy curriculum: Development & implementation. *Journal of Higher Education Theory & Practice, 21*(2). doi: 10.33423/jhetp.v21i2.4120

Le Boutillier, C., Chevalier, A., Lawrence, V., Leamy, M., Bird, V. J., Macpherson, R., … Slade, M. (2015). Staff understanding of recovery-orientated mental health practice: A systematic review and narrative synthesis. *Implementation Science, 10*(1), 1-14. doi: 10.1186/s13012-015-0275-4

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry, 199*(6), 445-452. doi: 10.1192/bjp.bp.110.083733

Lee, S., & Mackenzie, L. (2003). Starting out in rural New South Wales: The experiences of new graduate occupational therapists. *Australian Journal of Rural Health, 11*(1), 36-43. doi: 10.1046/j.1440-1584.2003.00476.x

Leigh, K., Whitted, K., & Hamilton, B. (2015). Integration of andragogy into preceptorship. *Journal of Adult Education, 44*(1), 9-17.

Liddiard, K., Batten, R., Wang, Y., Long, K., Wallis, A. & Brown, C. (2017). Job club: A program to assist occupational therapy students' transition to practice. *Education Sciences, 7*(3), 70. doi: 10.3390/educsci7030070

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, CA: Sage.

Lloyd, C., King, R., & Bassett, H. (2002). A survey of Australian mental health occupational therapists. *British Journal of Occupational Therapy, 65*(2), 88-96. doi: 10.1177/030802260206500207

Lloyd, C., King, R., & McKenna, K. (2004). Generic versus specialist clinical work roles of occupational therapists and social workers in mental health. *Australian & New Zealand Journal of Psychiatry, 38*(3), 119-124. doi: 10.1080/j.1440-1614.2004.01316.x

Lloyd, C., King, R., & Ryan, L. (2007). The challenge of working in mental health settings: Perceptions of newly graduated therapists. *British Journal of Occupational Therapy, 70*(11), 460-470. doi: 10.1177/030802260707001102

Lloyd, C., Tse, S., & Bassett, H. (2004). Mental health recovery and occupational therapy in Australia and New Zealand. *International Journal of Therapy and Rehabilitation, 11*(2), 64-70. doi: 10.12968/ijtr.2004.11.2.13392

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences, 1*(1), 31-42. doi: 10.1177/2632084320947559

McCombie, R. P., & Antanavage, M. E. (2017). Transitioning from occupational therapy student to practicing occupational therapist: First year of employment. *Occupational Therapy in Health Care, 31*(2), 126–142. doi: 10.1080/07380577.2017.1307480

McKenna, B., Furness, T., Dhital, D., & Ireland, S. (2014). Recovery-oriented care in older-adult acute inpatient mental health settings in Australia: An exploratory study. *Journal of the American Geriatrics Society, 62*(10), 1938-1942. doi: 10.1111/jgs.13028

McLachlan, K., Amigó, M. F., Rowe, A., Winchester-Seeto, T., Hutchison, J., & Williamson, K. (2017). Exploring critical success factors for effective collaborative relationships. In J. Sachs & L. Clark (Eds.) *Learning through community engagement* (pp. 231-243). Dordrecht, Netherlands: Springer. doi: 10.1007/978-981-10-0999-0_15

Mason, K., Ryan, A., & Bennett, H. (1988). *Report of the Committee of Inquiry into procedures in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients*. Wellington, New Zealand: Government Printer. https://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/2DC94A246D93272C4C2565D7000DDA26/%24file/Mason%20Report.pdf

Mathieu, F. (2007). *Transforming compassion fatigue into compassion satisfaction: Top 12 self-care tips for helpers.* Paper presented at the WHP-Workshops for Helping Professions. Retrieved February 7, 2020, from https://www.tendacademy.ca/wp-content/uploads/2007/10/Top-12-self-care-tips-for-helpers-updated-2016.pdf

Melman, S., Ashby, S. E., & James, C. (2016). Supervision in practice education and transition to practice: Student and new graduate perceptions. *Internet Journal of Allied Health Sciences and Practice, 14*(3), 1. doi: 10.46743/1540-580X/2016.1589

Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand: How things need to be.* Wellington, New Zealand: Author.

Mental Health Commission. (2007) *Te Haererenga mot e Whakaoranga 1996-2006*: *The journey of recovery for the New Zealand Mental Health Sector.* Wellington, New Zealand: Author.

Mental Health Commission. (2012). *Blueprint II: Improving mental health and wellbeing for all New Zealand: How things need to be*. Wellington, New Zealand: Author.

Mental Health Foundation. (2020). *Mental Health Foundation's call to action: Implement He Ara Oranga. Position statement*. Retrieved October 29, 2021, from https://archive.mentalhealth.org.nz/assets/policy-and-advocacy/Mental-Health-Foundations-call-to-action-Implement-He-Ara-Oranga-050820.pdf

Minister of Health (2016). *New Zealand health strategy: Future direction.* Wellington, New Zealand: Ministry of Health. Retrieved from

http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf

Ministry of Health. (2005). *Tauawhitia te wero: Embracing the challenge: National mental health and addiction workforce development plan 2006-2009*. Wellington, New Zealand: Author.

Ministry of Health. (2012). *Rising to the challenge: The mental health and addiction service development plan 2012–2017*. Wellington, New Zealand: Author.

Ministry of Health. (2014). The guide to He Korowai Oranga Maori health strategy. Retrieved December 1, 2021, from https://www.health.govt.nz/system/files/documents/publications/guide-to-he-korowai-oranga-maori-health-strategy-jun14-v2.pdf

Missen, K., McKenna, L., & Beauchamp, A. (2014). Satisfaction of newly graduated nurses enrolled in transition-to-practice programmes in their first year of employment: A systematic review. *Journal of Advanced Nursing, 70*(11), 2419-2433. doi: 10.1111/jan.12464

Missen, K., McKenna, L., & Beauchamp, A. (2016). Graduate nurse program coordinators' perspectives on graduate nurse programs in Victoria, Australia: A descriptive qualitative approach. *Collegian, 23,* 201-208. doi: 10.1016/j.colegn.2015.03.004

Moores, A., & Fitzgerald, C. (2017). New graduate transition to practice: How can the literature inform support strategies? *Australian Health Review, 41,* 308-312. doi: 10.1071/AH15240

Moorhead, B. (2019). Transition and adjustment to professional identity as a newly qualified social worker. *Australian Social Work, 72*(2), 206-218. doi: 10.1080/0312407X.2018.1558271

Moriarty, J., Manthorpe, J., Stevens, M., & Hussein, S. (2011). Making the transition: Comparing research on newly qualified social workers with other professions. *British Journal of Social Work, 41*(7), 1340-1356. doi: 10.1093/bjsw/bcr031

Morgan, D. A. (2019). Learning in liminality. Student experiences of learning during a nursing study abroad journey: A hermeneutic phenomenological research study. *Nurse Education Today, 79*, 204-209. doi: 10.1016/j.nedt.2019.05.036

Morley, M. (2009a). An evaluation of a preceptorship programme for newly qualified occupational therapists. *British Journal of Occupational Therapy, 72*(9), 384-392. doi: 10.1177/030802260907200903

Morley, M. (2009b). Contextual factors that have an impact on the transitional experience of newly qualified occupational therapists. *British Journal of Occupational Therapy, 72*(11), 507-514. doi: 10.4276/030802209X12577616538753

Morley, M., Rugg, S., & Drew, J. (2007). Before preceptorship: New occupational therapists' expectations of practice and experience of supervision. *British Journal of Occupational Therapy*, *70*(6), 243-253. doi: 10.1177/030802260707000604

Morrison, T., & Robertson, L. (2015). New graduates' experience of evidence-based practice: An action research study. *British Journal of Occupational Therapy, 79*(1), 42-48. doi: 10.1177/0308022615591019

Moxham, L., Taylor, E., Patterson, C., Perlman, D., Brighton, R., Sumskis, S., … Heffernan, T. (2016). Can a clinical placement influence stigma? An analysis of measures of social distance. *Nurse Education Today, 44*, 170-174. doi: 10.1016/j.nedt.2016.06.003

Mukhalalati, B. A., & Taylor, A. (2019). Adult learning theories in context: A quick guide for healthcare professional educators. *Journal of Medical Education and Curricular Development, 6*, 2382120519840332. doi: 10.1177/2382120519840332

Murray, M., Sundin, D., & Cope, V. (2019). Benner's model and Duchscher's theory: Providing the framework for understanding new graduate nurses' transition to practice. *Nurse Education in Practice, 34*, 199-203. doi: 10.1016/j.nepr.2018.12.003

Naidoo, D., Van Wyk, J., & Nat, R. J. (2014). Are final year occupational therapy students adequately prepared for clinical practice? A case study in KwaZulu-Natal. *South African Journal of Occupational Therapy, 44*(3), 24-28.

Naidoo, D., Van Wyk, J. M., & Dhunpath, R. (2018). Service learning pedagogies to promote student learning in occupational therapy education. *Africa Education Review*, 6627, 1-19. doi: 10.1080/18146627.2017.1340806

Nayar, S., Gray, M., & Blijlevens, H. (2013). The competency of New Zealand new graduate occupational therapists: Perceived strengths and weaknesses. *Australian Occupational Therapy Journal, 60*(3), 189-196. doi: 10.1111/1440-1630.12027

Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description – the poor cousin of health research? *BMC Medical Research Methodology, 9*(52). doi: 10.1186/1471-2288-9-52.

Nelson, G., Ochocka, J., Janzen, R., Trainor, J., Goering, P., & Lomotey, J. (2007). A longitudinal study of mental health consumer/survivor initiatives: Part V–Outcomes at 3-year follow-up. *Journal of Community Psychology, 35*(5), 655-665. doi: 10.1002/jcop.20171

New Zealand Government. (2018). *He Ara Oranga: Report of the Government Inquiry into mental health and addiction*. Retrieved July 30, 2021 from https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

Nicholls, D. (2009). Qualitative research: Part two – Methodologies. *International Journal of Therapy and Rehabilitation, 16* (11), 586-592. doi: 10.12968/ijtr.2009.16.11.44939

Nugent, A., Hancock, N., & Honey, A. (2017). Developing and sustaining recovery-orientation in mental health practice: Experiences of occupational therapists. *Occupational Therapy International, 24*(1), 1-9. doi: 10.1155/2017/5190901

O'Hagan, M., Reynolds, P., & Smith, C. (2012) Recovery in New Zealand: An evolving concept? *International Review of Psychiatry, 24*(1), 56-63. doi: 10.3109/09540261.2011.651447

O'Shea, M., & Kelly, B. (2007). The lived experiences of newly qualified nurses on clinical placement during the first six months following registration in the Republic of Ireland. *Journal of Clinical Nursing, 16*(8), 1534-1542. doi: 10.1111/j.1365-2702.2006.01794.x

Occupational Therapy Board of New Zealand. (2015). *Competencies for registration and continuing practice*. Retrieved July 1, 2021, from https://www.otboard.org.nz/document/4842/Competencies-Handbook.pdf

Occupational Therapy Board of New Zealand. (2021). *General scope of practice: Kaiwhakaora ngangahau occupational therapist.* Retrieved December 12, 2021, from https://otboard.org.nz/document/5885/Jan%202022%20Scope%20of%20Practice.pdf

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal, 31*(1), 9-22. doi: 10.2975/31.1.2007.9.22

Opoku, E. N., Khuabi, L. A. J. N., & Van Niekerk, L. (2021). Exploring the factors that affect the transition from student to health professional: An integrative review. *BMC Medical Education, 21*(1), 1-12. doi: 10.1186/s12909-021-02978-0

Oxford Dictionary. (n.d.). Retrieved September 5, 2021, from https://www.oxfordlearnersdictionaries.com/definition/english/transition

Pack, M. (2010). Allies in learning: Critical-reflective practice on-line with allied mental health practitioners. *Social Work Education, 29,* 1, 67-79. doi: 10.1080/02615470902810876

Parker, C. E. (1991). The needs of newly qualified occupational therapists. *British Journal of Occupational Therapy, 54*(5), 164-168. doi: 10.1177/030802269105400503

Patterson, C., Moxham, L., Brighton, R., Taylor, E., Sumskis, S., Perlman, D., … Hadfield, L. (2016). Nursing students' reflections on the learning experience of a unique mental health clinical placement. *Nurse Education Today, 46*, 94-98. doi: 10.1016/j.nedt.2016.08.029

Peris, T. S., Teachman, B. A., & Nosek, B. A. (2008). Implicit and explicit stigma of mental illness: Links to clinical care. *Journal of Nervous and Mental Disease, 196*(10), 752-760. doi: 10.1097/NMD.0b013e3181879dfd

Pfaff, K. A., Baxter, P. E., Jack, S. M., & Ploeg, J. (2014). Exploring new graduate nurse confidence in interprofessional collaboration: A mixed methods study. *International Journal of Nursing Studies, 51*(8), 1142-1152. doi: 10/1016/j.ijnurstu.2014.001

Pfeifer, T. A., Kranz, P. L., & Scoggin, A. E. (2008). Perceived stress in occupational therapy students. *Occupational Therapy International, 15*(4), 221-231. doi: 10.1002/oti.256

Procter, N., Beutel, J., Deuter, K., Curren, D., de Crespigny, C. & Simon, M. (2011). The developing role of transition to practice programs for newly graduated mental health nurses. *International Journal of Nursing Practice, 17*(3), 254-261. doi: 10.1111/j.1440-172X.2011.01932.x

Quick, L., Forsyth, K., & Melton, J. (2007). From graduate to reflective practice scholar. *British Journal of Occupational Therapy, 70*(11), 471-474. doi: 10.1177/030802260707001103

Randal, P., Stewart, M., Proverbs, D., Lampshire, D., Symes, J., & Hamer, H. (2009). The re-covery model – An integrative developmental stress–vulnerability–strengths approach to mental health. *Psychosis, 1*, 122-133. doi: 10.1080/17522430902948167

Reed, S., Shell, R., Kassis, K., Tartaglia, K., Wallihan, R., Smith, K., … Bradbury, S. (2014). Applying adult learning practices in medical education. *Current Problems in Pediatric and Adolescent Health Care, 44*(6), 170-181. doi: 10.1016/j.cppeds.2014.01.008

Repper, J., & Breeze, J. (2007). User and carer involvement in the training and education of health professionals: A review of the literature. *International Journal of Nursing Studies, 44*(3), 511-519. doi: 10.1016/j.ijnurstu.2006.05.013

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health, 20*(4), 392-411. doi: 10.3109/09638237.2011.583947

Rice, A. H. (2000). Interdisciplinary collaboration in health care: Education, practice, and research. *National Academies of Practice Forum: Issues in Interdisciplinary Care, 2*(1), 59-73. doi: 10.7899/JCE-14-36

Ridley, S., Martin, R., & Mahboub, L. (2017). Consumer involvement in the tertiary-level education of mental health professionals: A systematic review. *Australian Social Work, 70*, 372-380.

Robertson, L. J., & Griffiths, S. (2009). Graduates' reflections on their preparation for practice. *British Journal of Occupational Therapy, 72 (3),* 125-132. doi: 10.1177/030802260907200307

Rush, K. L., Adamack, M., Gordon, J., Lilly, M., & Janke, R. (2013). Best practices of formal new graduate nurse transition programs: An integrative review. *International Journal of Nursing Studies, 50,* 345-356. doi: 10.1016/j.ijnurstu.2012.06.009

Rush, K. L., Janke, R., Duchscher, J. E., Phillips, R., & Kaur, S. (2019). Best practices of formal new graduate nurse transition programs: An integrative review. *International Journal of Nursing Studies, 94,* 139-158. doi: 10.1016/j.ijnurstu.2019.02.010

Russinova, Z. (1999). Providers' hope-inspiring competence as a factor optimizing psychiatric rehabilitation. *Journal of Rehabilitation, 65*(4), 50-57.

Salyers, M. P., & Tsemberis, S. (2007). ACT and recovery: Integrating evidence-based practice and recovery orientation on assertive community treatment teams. *Community Mental Health Journal, 43*(6), 619-641. doi: 10.1007/s10597-007-9088-5

Samara, A. (2006). Group supervision in graduate education: a process of supervision skill development and text improvement. *Higher Education Research & Development, 25*(2), 115-129. doi: 10.1080/07294360600610362

Sandelowski, M. (2000). Focus on research methods: What happened to qualitative description? *Research in Nursing & Health, 23*(4)*,* 334-340. doi: 10.1002/1098-240x(200008)23:4<334::aid-nur9>3.0.co;2-g

Schmulian, D., Redgen, W., & Fleming, J. (2020). Impostor syndrome and compassion fatigue among postgraduate allied health students: A pilot study. *Focus on Health Professional Education: A Multi-Professional Journal, 21*, 1-14. doi: 10.11157/fohpe.v21i3.388

Seah, C. A., Mackenzie, L., & Gamble, J. (2011). Transition of graduates of the Master of Occupational Therapy to practice. *Australian Occupational Therapy Journal, 58*, 103-110. doi: 10.1111/j.1440-1630.2010.00899.x

Slade, M. (2009). *Personal recovery and mental illness: A guide for mental health professionals*. Cambridge, UK: Cambridge University Press.

Slade, M., Adams, N., & O'Hagan, M. (2012). Recovery: Past progress and future challenges. *International Review of Psychiatry, 24*(1), 1-4. doi: 10.3109/09540261.2011.644847

Slade, M., & Longden, E. (2015). Empirical evidence about recovery and mental health. *BMC Psychiatry, 15*(1), 285. doi: 10.1186/s12888-015-0678-4

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., … Whitley, R. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry: Official journal of the World Psychiatric Association (WPA), 13*(1), 12-20. doi: 10.1002/wps.20084

Smith, M., & Jury, A. F. (2017). Key initiatives in New Zealand's adult mental health workforce development. In A. Jury & M. Smith (Eds.), *Workforce development theory and practice in the mental health sector* (pp. 106-129). doi: 10.4018/978-1-5225-1874-7

Smith, R. A., & Pilling, S. (2007). Allied health graduate program – supporting the transition from student to professional in an interdisciplinary program. *Journal of Interprofessional Care, 21*(3), 265-276. doi: 10.1080/13561820701259116

Smith, R. A., & Pilling, S. (2008). Supporting the transition from student to professional – a case study in allied health. *Australian Health Review, 32,* 134-138. doi: 10.1071/ah080134

Smith-Merry, J., Freeman, R., & Sturdy, S. (2011). Implementing recovery: An analysis of the key technologies in Scotland. *International Journal of Mental Health Systems, 5*(1), 1-12. doi: 10.1186/1752-4458-5-11

Social Workers Registration Board. (n.d.) Retrieved December 1, 2021, from https://swrb.govt.nz/practice/scope-of-practice

Solowiej, K., Upton, P., & Upton D. (2010). Supporting the transition from student to practitioner: A scheme to support the development of newly qualified practitioners. *International Journal of Therapy and Rehabilitation, 17*(9)*,* 494-504.

Sorenson, C., Bolick, B., Wright, K., & Hamilton, R. (2016). Understanding compassion fatigue in healthcare providers: A review of current literature. *Journal of Nursing Scholarship, 48*(5), 456-465. doi: 10.1111/jnu.12229

Spandler, H., & Stickley, T. (2011). No hope without compassion: The importance of compassion in recovery-focused mental health services. *Journal of Mental Health, 20*(6), 555-566. doi: 10.3109/09638237.2011.583949

Spies, C., Seale, I., & Botma, Y. (2015). Adult learning: What nurse educators need to know about mature students. *Curationis, 38*(2), 1-7.

Spiva, L., Hart, P. L., Pruner, L., Johnson, D., Martin, K., Brakovich, B., … Mendoza, S. G. (2013). Hearing the voices of newly licensed RNs: The transition to practice. *The American Journal of Nursing, 113*(11), 24-32. doi: 10.1097/01.NAJ.0000437108.76232.20

Staniforth, B., & McNabb, D. (2004). Group supervision for new staff: A question of value. In L. Beddoe, J. Worrall & F. Howard (Eds.), *Weaving together the strands of supervision: conference proceedings of the supervision conference* (pp. 147-152). Auckland, New Zealand: The University of Auckland.

Stanley, M., & Nayar, S. (2014). Methodological rigour: Ensuring quality in occupational therapy qualitative research. *New Zealand Journal of Occupational Therapy, 61*(1), 6-12.

Sutton, G., & Griffin, M. A. (2000). Transition from student to practitioner: The role of expectations, values and personality. *British Journal of Occupational Therapy, 63*(8), 380-388. doi: 10.1177/030802260006300805

Sweeney, G., Webley, P., & Treacher, A. (2001). Supervision in occupational therapy, part 3: Accommodating the supervisor and the supervisee. *British Journal of Occupational Therapy, 64*(9), 426-431. doi: 10.1177/030802260106400902

Taylor, D. C., & Hamdy, H. (2013). Adult learning theories: Implications for learning and teaching in medical education: AMEE Guide No. 83. *Medical Teacher, 35*(11), 1561-1572. doi: 10.3109/0142159X.2013.828153

Te Pou o Te Whakaaro Nui. (n.d.) Retrieved June 9, 2017, from https://www.tepou.co.nz

Te Pou o te Whakaaro Nui. (2015). *Adult mental health and addiction workforce: 2014 survey of Vote Health funded services*. Auckland, New Zealand: Te Pou o te Whakaaro Nui

Te Pou o Te Whakaaro Nui. (2017a). *Workforce stocktake*. https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/Te-Pou-Stocktake.pdf

Te Pou o Te Whakaaro Nui. (2017b). *Follow up results of Skills Matter students from 2015*. Retrieved June 1, 2017, from https://www.tepou.co.nz/resources/2016-skills-matter-follow-up-of-skills-matter-students-of-2015

Te Pou o Te Whakaaro Nui. (2018a). *Student survey results for 2017: Evaluation report of courses funded under the Skills Matter programme*. Retrieved June 1, 2019, from https://www.tepou.co.nz/resources/2017-skills-matter-student-survey-results

Te Pou o Te Whakaaro Nui. (2018b). *Let's get real: The right knowledge, skills, values and attitudes to effectively support people using services.* Retrieved August 30, 2021, from https://www.tepou.co.nz/initiatives/lets-get-real/107

Te Pou o te Whakaaro Nui., & Matua Raki. (2015). *More than numbers workforce stocktake.* Auckland, New Zealand: Te Pou.

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. In C. Willig & W. Stainton Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (pp.17-37). London, UK: SAGE.

Thomas, J. (2013). Association of personal distress with burnout, compassion fatigue, and compassion satisfaction among clinical social workers. *Journal of Social Service Research, 39*(3), 365-379. doi: 10.1080/01488376.2013.771596

Thorne, S. (2008). *Interpretive description.* Walnut Creek, CA: Left Coast Press.

Thorne, S. E. (2016). *Interpretive description: Qualitative research for applied practice* (2nd ed.). NY: Routledge.

Thorne, S., Reimer Kirkham, S., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing and Health, 20*(2), 169-177. doi: 10.1002/(sici)1098-240x(199704)20:2<169::aid-nur9>3.0.co;2-i

Thorne, S., Reimer Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3* (1), 1-11. doi: 10.1177/160940690400300101

Toal-Sullivan, D. (2006). New graduates' experiences of learning to practise occupational therapy. *British Journal of Occupational Therapy, 69*(11), 513-524. doi: 10.1177/030802260606901105

Tondora, J., Miller, R., Slade, M., & Davidson, L. (2014). *Partnering for recovery in mental health: A practical guide to person-centered planning.* NY: John Wiley & Sons.

Torre, D. M., Daley, B. J., Sebastian, J. L., & Elnicki, D. M. (2006). Overview of current learning theories for medical educators. *The American Journal of Medicine, 119*(10), 903-907. doi: 10.1016/j.amjmed.2006.06.037

Tryssenaar, J., & Perkins, J. (2001). From student to therapist: Exploring the first year of practice. *American Journal of Occupational Therapy, 55*(1), 19-27. doi: 10.5014/ajot.55.1.19

Turpin, M., Fitzgerald, C., Copley, J., Laracy, S., & Lewis, B. (2021). Experiences of and support for the transition to practice of newly graduated occupational therapists undertaking a hospital graduate program. *Australian Occupational Therapy Journal, 68*(1), 12-20. doi: 10.1111/1440-1630.12693

Verenikina, I. 2004). From theory to practice: What does the metaphor of scaffolding mean to educators today? *Faculty of Social Sciences – Papers,* 1025. https://ro.uow.edu.au/sspapers/1025

Webber, M., & Joubert, L. (2015). Editorial: Social work and recovery. *British Journal of Social Work*, *45*(Supp. 1), S1-S8. doi: 10.1093/bjsw/bcv125

Wenger-Trayner, E., & Wenger-Trayner, B. (2015). *Communities of practice: A brief introduction*. http://wenger-trayner.com/wp-content/uploads/2015/04/07-Brief-introduction-to-communities-of-practice.pdf

Whitehead, B. (2014). Preceptorship. *Nursing Standard, 28*(25), 72-73.

Whitehead, B., Owen, P., Henshaw, L., Beddingham, E., & Simmons, M. (2016). Supporting newly qualified nurse transition: A case study in a UK hospital. *Nurse Education Today, 36*, 58-63. doi: 10.1016/j.nedt.2015.07.008

World Health Organization (2010). *Framework for action on interprofessional education and collaborative practice.* https://apps.who.int/iris/bitstream/handle/10665/70185

World Health Organization (2013). *Mental health action plan 2013-2020*. Geneva, Switzerland: Author. http://www.who.int/iris/handle/10665/89966

World Health Organization. (2019a). *Mental disorders fact sheet*. Author. https://www.who.int/news-room/fact-sheets/detail/mental-disorders

World Health Organization. (2019b*). The WHO special initiative for mental health (2019-2023): Universal health coverage for mental health*. Author. https://apps.who.int/iris/handle/10665/310981

Zapatka, S. A., Conelius, J., Edwards, J., Meyer, E., & Brienza, R. (2014). Pioneering a primary care adult nurse practitioner interprofessional fellowship. *The Journal for Nurse Practitioners, 10*(6), 378-386. doi: 10.1016/j.nurpra.2014.03.018

Appendices

Appendix A: AUTEC Approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

15 October 2018

Ellen Nicholson
Faculty of Health and Environmental Sciences

Dear Ellen

Ethics Application: **18/383 Novice practitioners' perceptions of engaging in a specialist mental health and addictions transition to practice programme**

Thank you for submitting your application for ethical review. I am pleased to advise that a subcommittee of the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application, subject to the following conditions:

1. The committee notes that the study examines organisational practices (H.14). Please reflect on how these will be managed if organisational risks (e.g. extremely critical views of the training provide) emerge during the study;
2. The committee suggests that the recruitment email refers to an attached Information Sheet, so that interested persons can find out more about the research rather than having to ask separately to receive the information;
3. Amendment of the Information Sheet as follows:
    a. Include advice that health information regarding consumers/patients/clients will not be disclosed during focus groups without their consent;
    b. Remove the offer of AUT counselling since it will not be available to persons who live outside the Auckland area, but consider alternatives if emotional concerns arise;
    c. Remove the statements around injury compensation;
    d. Add the current AUT logo.

Please provide me with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires copies of any altered documents, such as Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

Please note that the Committee is always willing to discuss with applicants the points that have been made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

I look forward to hearing from you,

Yours sincerely

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: suzanne.patterson@outlook.com; Brian McKenna

Appendix B: Description of Allied Health NESP Programme

The origins of the NESP programme were founded upon an occupational therapy recruitment initiative within the Auckland District Health Board in the 1990's, that employed graduates to an internship programme providing rotational placements across mental health and addiction services. The programme's inception was a response to recognising new graduates recruited within mental health required additional knowledge, skills and support to practice confidently within this specialist area, despite having had mental health placements during undergraduate training. Based on the programmes' success, collaborative efforts of occupational therapy and social work leaders lead to this model being adopted nationally in Aotearoa, with funding for a post-graduate programme being secured under the Mental Health Workforce Development Project. An academic component was added to the programme, which was contracted out to tertiary providers, and was first delivered through Victoria University in Wellington in 2003. The NESP programme was later contracted to the Auckland University of Technology (AUT) in 2010 and continues to be provided by this institution to date.

The aim of the NESP programme is to increase the confidence and competence of graduates working within mental health and addictions and was designed for social work and occupational therapy graduates who were in their first two years of practice within the sector. Programme entry requirements included trainees having social work or occupational therapy undergraduate qualifications, be employed in a clinical role of at least 0.6 full-time equivalent within mental health and addictions services and having their employers approval to apply. This was later extended in 2018 to also include nursing graduates and trainees from other disciplines within the programme. Places on the programme can be self-funded (e.g. through employers or independently) or trainees can apply for Te Pou o te Whakaaro Nui funding to attend. Funding for NESP includes course fees, additional supervision, trainee release time to attend teaching blocks, with additional grants available to support programme attendance (e.g. travel, accommodation). There were approximately 45 funded NESP trainees on each year of the programme between 2015-2017.

Programme Components

The NESP programme content closely aligns with the values of both occupational therapy and social work disciplines and is based on the 'Let's Get Real' values (Te Pou o Te Whakaaro Nui, 2018b). The programme content is overseen by the NESP co-ordinator whose role is to develop teaching/learning resources and facilitate delivery of programme content. Additional responsibilities include partnering with employers, monitoring NESP supervision provision and resolving any student/employer issues related to the programme. Knowledge and skill development of trainees is progressed through both academic and clinical practice components.

Academic Component

In 2015-2017 the academic component of NESP consisted of two masters level papers that formed a Post Graduate Certificate in Health Science (Mental Health and Addictions). In the first semester trainees completed the *Mental Health Practice* paper that supported acquisition of foundational skills for engaging with consumers and whanau, knowledge of fundamental mental health and addiction assessments and interventions and gaining experience utilising these in practice. Assessment for the paper consisted of two clinical case studies demonstrating application of both mental health assessment and interventions, and critical reflections on trainees discipline specific roles within mental health service delivery.

In the second semester trainees completed the *Concepts of Recovery in Mental Health* paper that examined service user views of recovery and mental distress, recovery frameworks and theory, determinants of well-being and application of person-centred, recovery-oriented principles in practice. Assessment for the paper consisted a literature review focused on personal recovery and an audit of one aspect of mental health service delivery against recovery-oriented principles.

Programme Delivery

The academic component of NESP was delivered over four teaching blocks, two per semester, consisting of three and four days of on-campus learning provided in both Auckland and Christchurch. Academic content was augmented through optional learning tasks, readings and the provision of online resources. The programme content was presented by lecturers of varied disciplines employed in mental health such as occupational therapists, social workers, psychiatrists, psychologists, nurses and clinical specialists. Experts with lived experience, whanau and cultural workers formed an integral part of the teaching team. Discipline specific clinical educators also supported trainees developing clinical knowledge and skills for mental health practice by aiding with assignments, academic writing, understanding programme content and offering pastoral care as required.

Practice Component

In conjunction with completing the academic papers, trainees were required to set professional development goals, attend fortnightly NESP supervision (in addition to mandatory professional supervision requirements) and create an online practice portfolio that evidenced their professional development and practice development over the NESP year. Trainees were also expected to complete at least 1000 hours of clinical work in mental health and addiction practice.

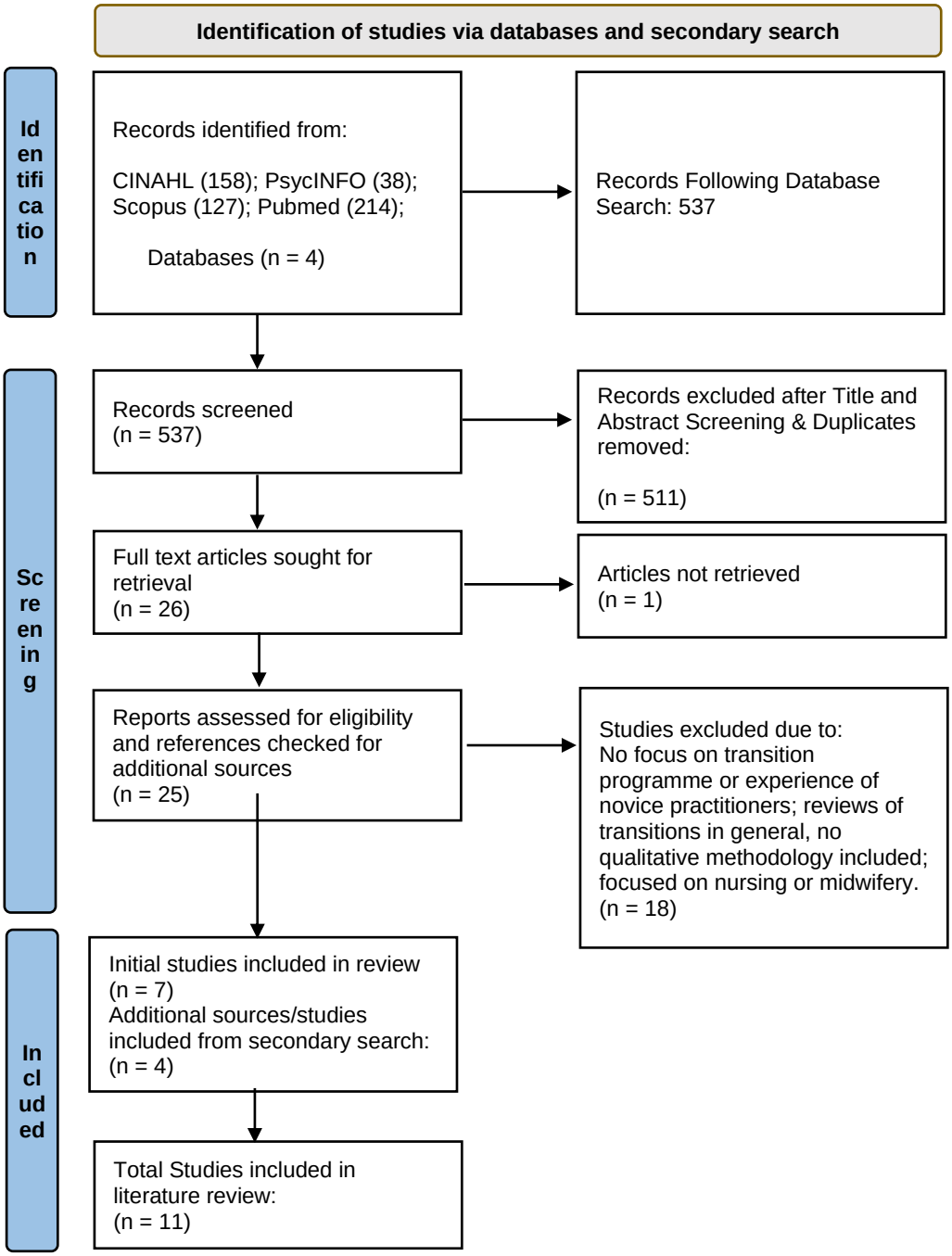
Employers needed to give trainees permission to participate in NESP and were required to sign a partnership agreement outlining their obligations for the duration of the programme to receive NESP funding/reimbursement. This included employers releasing trainees to attend teaching blocks, self-directed study days, NESP supervision and providing clinical experience opportunities for trainees to apply new learning in context. Employers allocated trainees a supervisor from the same discipline to assist with professional development, practice issues and completing NESP requirements. Additionally, a mentor based within trainees services were allocated to provide informal day-to-day support, feedback and to oversee trainees practice for the duration of the programme. Mentor roles were not funded.

(Te Pou o Te Whakaaro Nui, n.d.).

Appendix C: Extended Search Terms

Search terms included: allied health; social work; occupational therapy; new graduate; novice; novice practitioner; neophyte practitioner; transition; transition to practice; transition programme; entry to practice; graduate programme; graduate experience; mental health; addiction; support programme; preceptor; preceptorship; mentor; mentorship; and truncations of terms in varied combinations.

Appendix D: Search Strategy and Results



Adapted from *The PRISMA 2020 statement: an updated guideline for reporting systematic reviews* by Page M. J. et al., (2020). From: Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., et al. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *British Medical Journal, 372*(n71). doi: 10.1136/bmj.n71

Appendix E: Summary of Articles Accessed

Author/Location	Purpose	Methodology/Methods Participants	Key Findings related to Participants Experiences of Programme	Transition programme details	Strengths & Weaknesses
Banks, Roxburgh, Kane, Lauder, Jones, Kydd & Atkinson (2011) Location: Scotland	To evaluate the impact and effectiveness of Flying Start NHS on confidence, competence and career development of newly qualified nurse, midwives and allied health professions in NHS Scotland. Primary care setting	Qualitative: Descriptive Design 1:1 & Focus Group Interviews Multi Methods: Focus Groups & Telephone Interviews Scoping telephone interviews with lead coordinators n = 21 and mentors n = 22; Focus groups with NQP's n = 95; Online Survey NQP's n = 547(primary data source) (OT's n=45; No SW; AH NQP's 189) Employed 6-18 mos.	Increased clinical skill development & confidence; Protected time more likely to complete and report good support; 4/5 could not use the time had to do in own time and find own peer support; Need mentors available; Mentors need more time and training to provide better support; Poor support from mentors lead to 1 NQP leaving programme; Some mentors unaware of prog or did not know it well. FG – imbalance between expectations of prog and support given. Needs support from workplace; More likely to complete if supported well. High workloads and competing demands. High number had not completed online programme at 1 year in their post.	Flying Start NHS Web-based prog to be completed within 12mos of starting; Mentor support; Aims to support the transition. 10 learning units can choose activities to meet these; Ends each unit with concluding activity. Protected time ranged from 1-6hrs/mo.	Strengths: independent evaluation; ethical approval; Appropriate methods – 'fit' with inquiry. High numbers. Varied views accessed. Limitations: Did now know numbers of all staff doing the prog; Not all surveys were fully completed;
Erol, Upton & Upton (2016) Location: Scotland	To identify factors leading to successful completion of Flying Start	Qualitative Semi-structured telephone interviews & focus groups 6 months pre and post completion. Framework Analysis: Aims to describe, decode and understand the meaning, not freq. of social phenomena. Interviews with management (n = 23), Interviews with practitioners (n = 22), focus groups (n = 11). AHP's (n = 13)	Themes: Management and Delivery; Content & Material; Participation & Completion. Challenges: lack of protected time; had to do in own time; high workloads and competing demands; IT difficulties. Benefits: flexibility; online format; Worked best if agreed tasks at outset; Supervision and monitoring enhanced progress; Marked development; Good for career progression and professional development; able to use for professional body. Recommendations: Mentors key factor in completion; Org. needs to support and value; Shared expectations between NQP and mentor supported progress; Need consistency with agreeing completion; Acknowledge the end. Include graduates as future mentors. Further research of online platforms.	Flying Start NHS Online prog to be completed within 12mos of starting; Includes work based learning & mentor support; Aims to support the transition.	Strengths: Wide range of locations and NQP's; Independent evaluation; Multi methods; data collected both managers and NQP's view. Good audit trail Limitations: No ethical approval – seen as an audit. Low no. of participants; reduced transferability. No other major weaknesses
Fitzgerald, Moores, Coleman & Fleming (2015) Location: Australia	To investigate method to support new graduates in clinical learning and development	Action Research - Qualitative analysis. Insider action research methodology. Developed framework and piloted. Pre and post surveys 6 months either side; 5 likert scales and 13 open-ended questions. Thematic analysis of open ended responses Participants (n = 16) new grads and associated clinical educators. All OT - No SW; No males; Experience: 1yr (n= 3) 2yr (n = 4)	Findings: two overarching themes: (i) Contribution to learning goal development and (ii) Compatibility with existing learning supports. Benefits: linking to learning resources and opportunities; Goal achievement supported; Clinical educators' motivators and role models for engagement in learning; Achievement recognised. Participants: greater clarity of goals and setting new goals; Recognised achievement and progress; Gave structure to supervision; Extended focus beyond just clinical skills to wider professional skills such team workin/interpersonal skills. Conclusions: Learning framework showed utility to support new grads. Recommended: Further long term investigation; Use with supervisors and clinical educators; Increase inter-professional use; Increased support to meet workplace demands needed.	Pilot of the OTCLF - OT Clinical Learning Framework – Provided resources for goal planning with clinical educators; Linked graduates to resources; and opportunities to apply. Monthly review; Also met with supervisors.	Strengths: Ethical approval Strong analysis & discussion; Had participants quotes; Limitations: Small sample size; Query bias of reporting; Time frame of evaluation too short to see full benefits.
Liddiard, Batten, Wang, Long, Wallis & Brown (2017) Australia	To increase awareness of occupational therapy graduates need for support through transition period.	Case Study: A university initiative to ease transition to practice Quality improvement survey reported Sample size not reported	Job Club eased transition from graduate to occupational therapist. Benefits: informal and flexible; not highly formalized process. Adapts to graduate needs; Builds peer support and networking; Supported professional identity; Increased skills and confidence; Built a sense of contribution to the group; Recommend longitudinal study and formal research be conducted.	Job Club' – bi-monthly group; Initial aim was support for job seeking and networking; Became support to transition to practitioners. 12 months; Run by local university.	Limitations: Not formal research study; Little participant feedback reported. No method etc. Authors recognise it is informal.

Morley (2009a) UK	To evaluate the extent to which preceptorship programme ameliorated the challenges of transition	Qualitative Preceptorship Programme evaluation – audit Template analysis Semi-structured interviews at 6 and 12 months; Pilot of 1yr OT's (n = 4) Preceptors (n = 4) (n = 8)	Findings Themes: - Feeling motivated to engage in preceptorship - Feeling supported to engage in preceptorship - Being clear about the preceptor process - Agreeing expectations - Engaging in effective supervision - Being confident to engage in observed practice - Using preceptorship improved practitioners' skills Recommendations included: applied learning in practice; more joint working and role-modelling; Management must understand it.	Preceptor Pilot - Core tasks to complete linked to competencies Included observed practice and feedback Pay incentive at 6 and 12 months	Strengths: Well documented research process; Limitations: Transferability; small scale study; Insider Research;
Morley (2009b) UK	To understand the contextual factors that impact transition of NQOT's	Mixed Methods evaluation Template analysis Semi-structured interviews at 6 and 12 months OT's (n = 4) Preceptors (n = 4) (n = 8)	Findings: Themes: - Job design - Realities of practice - Team working - Professional identity - Development strategies Contextual and individual factors influence effectiveness	Preceptorship Programme Pilot - Core tasks to complete linked to competencies Included observed practice and feedback Pay incentive at 6 and 12 months	Strengths: Well documented research process; Limitations: Transferability; small scale study; Insider Research.
Smith & Pilling (2007) Australia	To explore graduates and facilitators experience of the pilot programme	Programme Evaluation Pilot – Written graduate feedback (n = 14)	Findings – Themes from feedback based on programme objectives. Networking opportunities were a strength; Peer support was reassuring. Challenges: time management; dealing with full time work; having responsibility for a full caseload; decision making about patient care; less access to supervision; understanding how health system works; conveying opinions and delegating to others. Recommended controlled study of programme vs. no programme of graduates.	Interprofessional Allied Health graduate programme 12 x 2hr sessions over 10 months.	Limitations: Methods and analysis vague; little methodological trail or evidence of a robust process However provides good background Findings relevant for practice.
Smith & Pilling (2008) Australia	To describe process and outcomes of allied health transition programme	Case Study Reporting outcomes of 3yrs of programme Used participant feedback to understand experience of those on programme Unclear 11-13 per year Includes both SW and OT	Findings: Programme eased the transition; improved retention rates. Benefits: Peer support; reduces isolation; increased knowledge of other roles; Facilitated sessions are useful – mix of open and structured activities; Interprofessional learning	Interprofessional Allied Health graduate programme 8 x 2hr sessions and an end-of-year reflection.	Limitations: Methods and analysis vague; no evidence of methodological trail or evidence of robust process. Findings relevant for practice.
Solowiej, Upton & Upton (2010) Scotland	To assess impact of Allied Health Support & Development Scheme on recruitment, retention and career development of NQP's.	Pilot project Mixed methods Quant – SPSS Qual – Content Analysis. Independent evaluation (n = 154)	Qualitative Findings: Themes: Role of Mentors; Support Funding Valued; Volume of Work High was main concern; Quantitative Findings: 86% said scheme was positive and supported transition. Recommendations: consider impact of recruitment and retention; explore mentor support further; explore expectations of NQP's about the transition to determine transitional needs in allied health.	Online learning; mentor support and financial incentives. 24 months: Yr 1 online modules and portfolio of evidence. Yr 2 focus on projects to improve patient care and reflective summary. Access to funds and dependent on successful completion	Strengths: Ethical approval; Good methodological trail; Robust; Independent researchers; Limitation: transferability as is an audit;

Te Pou (2017) New Zealand	To evaluate student satisfaction with content and support of transition programme.	Quality assurance evaluation Student survey Quant and Qual elements (n = 16) Approx (n = 8) OT Approx (n = 5) SW	Satisfied with course; Received sufficient support and mentoring; Could use learning in practice; increased employment opportunities; Increased confidence and competence; more able to work with MH clients: Challenges – balancing workload and study; and family life. Positively influenced practice; better outcomes for clients.	Allied Health New Entry to Specialist Practice – Mental Health and Addictions PG Cert Academic and clinical components	Strengths: Accessed voice of graduates; Participants well defined; survey questions evident Limitations: Audit; not peer reviewed; Grey literature; limitations not considered in study
Te Pou (2018) New Zealand	To evaluate student satisfaction with transition programmes.	Evaluation Student Survey - Evaluation form either in person on last day of course or digital online survey. Student Survey (n = 251) AH (n = 20)	Found courses valuable; positively affected practice; better outcomes for clients; inspired to remain in mental health and addictions workforce; Professional qualifications valued; Had sufficient support Challenges: balancing workload and study;	Evaluating number of transition programmes to specialist practice – AH NESP was one of these.	Strengths: Accessed voice of graduates; Sample well defined; survey questions evident Process clear; Limitations: eval report from funder. Not peer reviewed. Grey literature. But relevant to current programme.

Appendix F: Overview of Research Selected for Review

The literature included for review was from varied locations internationally including Australia (Fitzgerald, Moores, Coleman, & Fleming, 2015; Liddiard et al., 2017; Smith & Pilling, 2007, 2008); Scotland (Banks et al., 2011; Erol, Upton, & Upton, 2016; Solowiej, Upton, & Upton, 2010); the United Kingdom (Morley, 2009a, 2009b); and Aotearoa New Zealand (Te Pou o te Whakaaro Nui, 2017b, 2018a). There was a notable lack of literature from Canada, continental Europe, and the United States.

Most studies accessed in the literature review were evaluations (Banks et al., 2011; Erol et al., 2016; Solowiej et al., 2010; Te Pou o te Whakaaro Nui, 2017b, 2018a), pilot studies (Fitzgerald et al., 2015; Morley, 2009a; Smith & Pilling, 2007), or case study examples (Liddiard et al., 2017; Smith & Pilling, 2008). The focus of the case studies was evaluating transition programmes from the perspectives of graduates or in conjunction with support and management staff attached to the programmes. The remaining studies specifically explored factors impacting novice practitioners' successful completion of transition programmes (Morley, 2009b; Solowiej et al., 2010); while Liddiard et al.'s (2017) 'job club' initiative presented an informal example of a graduate support transition programme that aimed to ease the transition from student to health professional. The literature highlights the diversity in terms of how this area of practice has been researched to date which may be also hampered by the variation in transition programme composition and included components.

The case study presented by Liddiard et al. (2017) did not explicitly use a structured methodology. Rather, this described a 'quality improvement activity' that obtained feedback from participants as part of their evaluation processes. While Smith and Pilling (2008) reviewed three years of graduate feedback in their interprofessional transition programme evaluation, only four of the studies collected data over time. This included interviewing participants both pre- and post- completion of the transition programmes (Erol et al., 2016; Fitzgerald et al., 2015), or during and after completion of the programmes (Morley 2009a, 2009b). These were the only studies conducted over time suggesting that understanding the longitudinal experiences of practitioners completing transition programmes has not yet been fully explored within current available literature.

Of the 11 articles included, six employed qualitative methodologies that sought to capture the perspectives of novice practitioners undertaking transition to practice programmes (Banks et al., 2011; Erol et al., 2016; Fitzgerald et al., 2015; Morley 2009a; Smith & Pilling, 2007, 2008). One of these utilised an insider action approach to the research process (Fitzgerald et al.,

2015). A further four employed mixed method evaluations of transition programmes using a combination of quantitative measures and qualitative feedback to examine the impact, outcomes, or satisfaction of novice practitioners completing transition programmes (Morley, 2009b; Solowiej et al., 2010; Te Pou o te Whakaaro Nui, 2017b, 2018a). However, only a small number of pure qualitative explorations of the perceptions of novice allied health practitioners' experiences completing transition to practice programmes have been conducted globally (Erol et al., 2016; Morley, 2009a).

The research methods of the studies reviewed ranged from semi-structured individual interviews (Morley 2009a, 2009b), combined with focus group interviews (Banks et al., 2011; Erol et al., 2016), or the use of surveys or questionnaires (Smith & Pilling, 2007, 2008; Solowiej et al., 2010; Te Pou o te Whakaaro Nui, 2017b, 2018a). Strengths of the more recent studies employing solely qualitative methodologies included utilising research methods congruent with their chosen methodologies, well documented research processes and audit trails detailed throughout the studies (Banks et al., 2011; Erol et al., 2016; Morley, 2009a, 2009b). Reporting findings as themes was a further way the studies maintained methodological congruence, and reporting participant comments and quotes as part of the study findings contributed to the rigour of these studies. The use of independent evaluators from outside the organisation providing the transition programmes added to the credibility and trustworthiness of findings and reduced potential bias of findings. Only Liddiard et al.'s (2017) and Smith and Pilling's (2007, 2008) case study examples lacked examples or detail of the assessment tools used to gather qualitative data.

Participant sample sizes in the studies reviewed ranged from 8 (Morley 2009a, 2009b) to 547 (Banks et al., 2011). Though the studies referred to allied health practitioners, the professions and disciplines of participants reported in the studies varied significantly. Several studies included newly qualified nurses and midwives together with allied health professionals as participants (Banks et al., 2011; Erol et al., 2016; Te Pou o te Whakaaro Nui, 2018a). Five studies included a broad range of allied health practitioners that included both social work and occupational therapy participants (Smith & Pilling, 2007, 2008; Solowiej et al., 2010; Te Pou o te Whakaaro Nui, 2017b, 2018a). Four studies focused solely on occupational therapy novice practitioners (Fitzgerald et al., 2015; Liddiard et al., 2017; Morley 2009a, 2009b); while no studies were found that solely explored the perspectives of novice social work practitioners undertaking transition to practice programmes. Other studies included the perspectives of support and management staff of transition programmes in conjunction with those of novice practitioners completing the programmes (Banks et al., 2011; Erol et al., 2016; Fitzgerald et al.,

2015; Morley 2009a, 2009b; Smith & Pilling, 2007). Overall, there seemed to be a marked lack of research that included both social work and occupational therapy clinicians as participants.

In relation to clinician practice areas, all participants in Te Pou o te Whakaaro Nui's (2017b, 2018a) evaluations were from mental health and addiction settings. This provided some insights into the perspectives of novice allied health practitioners working within this specialist practice area, which is relevant to the focus of the current study. Several studies did not explicitly detail the clinical practice areas of participants engaging in transition programmes (Liddiard et al., 2017); instead, described the organisation or geographical area within which participants were practicing (Smith & Pilling, 2007, 2008; Solowiej et al., 2010). Morley's (2009a) initial evaluation indicated participants were selected from "a range of contexts" (p. 386). In Morley's (2009b) later study, service settings were specified as acute hospitals, paediatrics, mental health services including both acute and day services. Erol et al. (2016) described participants occupying acute, community, and rotational posts though did not indicate if these were physical or mental health service settings. Fitzgerald et al. (2015) stated participants were practicing within acute physical health services in a metropolitan setting and clearly detailed not including novice allied health practitioners working in mental health and addiction services, which was reflective of the wider limited research available at present in this area of practice. Overall, this overview of the research suggests that while there is a growing body of literature in this area, there is little consistency as to how the phenomena has been explored and there are gaps in current research that further research could begin to address.

Appendix G: Recruitment Email and Research Invitation

Auckland University of Technology

Private Bag 92006, Auckland 1142, NZ

T: +64 9 921 9999

www.aut.ac.nz

Subject: Research Invitation: Allied Health New Entry to Specialist Practice Programme

Kia ora,

An Invitation:

You are invited to take part in a research project entitled: *Novice Practitioners' Perceptions of Engaging in a Specialist Mental Health and Addictions Transition to Practice Programme* which is being undertaken by Suzanne Patterson as part of a Masters thesis at Auckland University of Technology. The project is being supervised by Dr Ellen Nicholson, Head of Department, School of Occupational Science and Therapy, Auckland University of Technology.

An invitation to participate is being extended to you because you are a graduate of the Allied Health NESP: Mental Health and Addictions Programme who completed the programme in 2015-2017.

Research Description and Purpose:

The research project aims to find out about your experience of being a novice practitioner on the Allied Health NESP Mental Health and Addictions programme, to explore your perceptions of engaging in the programme and how it has impacted on your transition to professional practice.

Findings are intended to increase understanding of the role of the programme in the transition to practice for novice practitioners, expand the understanding of the needs of practitioners undertaking the programme and to contribute to informing aspects of future programme delivery. Ethical approval for this study has been granted by the Auckland University of Technology Ethics Committee.

What does it involve?

Research is always voluntary so you are under no obligation to take part in this study, but if you decide to take part, you will be asked to be involved by attending a focus group with other participants to share your perceptions of engaging in the programme and what it was like being a NESP practitioner. There is an Information Sheet attached to this email that provides further detailed information about the research and what it involves should you wish to find out more about the project before making a decision.

If you are interested in participating in the research project, need further information or have any questions or queries about this, then please contact the researcher or the project supervisor at the below contact details:

Researcher Contact Details: Suzanne Patterson. Email: Suzanne.Patterson@outlook.com. Contact: 03 3765229

Project Supervisor Contact Details: Dr Ellen Nicholson. Email: Ellen.Nicholson@aut.ac.nz. Contact: 09 921 9999

Nga Mihi

Sent by AH NESP Programme Administrator On behalf of Suzanne Patterson

Appendix H: Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

25th July 2019

Project Title: Novice Practitioners' Perceptions of Engaging in a Specialist Mental Health and Addictions Transition to Practice Programme

An Invitation

Kia ora. My name is Suzanne Patterson and I am an Occupational Therapist and Clinical Educator on the New Entry to Specialist Practice: Allied Mental Health & Addictions (NESP) programme offered at AUT. I have a background of working in many different areas of mental health and am passionate about supporting and equipping others to work alongside some of the more vulnerable members of our society who access mental health services. I have been working on the programme supporting NESP trainees for the past four years and over this time I have become interested in understanding how the programme has contributed to the development of clinicians and how it has supported their journey as practitioners.

This research is a study focused on gaining your perspective of being part of the NESP programme and how this has impacted on your transition to mental health and addictions practice. I would like to invite you to take part in the research project which will involve participating in a focus group discussion of approximately 1-2hours with other NESP graduates from 2015-2017. The focus of this research is to understand how the course has supported your transition to practice as a mental health and addictions clinician, what your experience of being a NESP practitioner was like and to consider any recommendations you might have about the programme for future change. Your time and participation will be greatly appreciated.

Participation is voluntary and you may choose to not answer some questions or participate in some aspects of the discussion, and can withdraw from the group, or the research study itself at any stage if you wish to do so. If you do withdraw from the study, removal of data is outlined below and on the accompanying informed consent form.

This research is being completed as part of a Masters of Health Science qualification at AUT and a thesis report of findings will be submitted for assessment to the university. Additionally findings will be shared with key stakeholders of the programme, Te Pou and the AUT NESP advisory governance group. It is anticipated that a journal article written will be written and findings presented at national OT conference.

What is the purpose of this research?

This study primarily focuses on your experiences of being a NESP clinician, what this was like for you and how it supported your transition to practice in specialist mental health and addictions services. It will also explore any barriers and facilitators to your participation and it is anticipated that findings may inform clinical thinking related to ongoing programme delivery and to adapt and improve the programme to better meet the needs of future NESP trainees.

How was I identified and why am I being invited to participate in this research?

You were identified because you were a graduate of the AH NESP Programmes of 2015-2017. You have been invited to participate because you have the experience of completing the programme and can offer valuable insights and understandings into what this has been like that have not yet been explored.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

Consent is given when you sign the consent form in the accompanying email, and will need to be completed prior to participating in the focus group. This will provide further details of withdrawal from the research and any concerns regarding withdrawal of data. This will also address confidentiality requirements of participating in a focus group interview.

What will happen in this research?

You are invited to participate in a focus group involving the primary researcher and 6-8 participants, sharing your views and perspectives of your experience of being part of the NESP programme and transitioning to clinical practice in mental health and addictions. Focus groups will take place at major geographical locations around New Zealand to allow as many practitioners as possible to participate – these will take place in Christchurch and Auckland. Details of venue will be provided once confirmed. Focus groups will be audio-recorded and it is anticipated they will require 1-2 hours of your time. Notes will also be taken during the session to assist with coding data and de-identifying participants to maintain anonymity. Data collected during the group will only be utilised for the express purposes that it was intended for, that you have provided consent for, and that AUT Ethics Committee have also granted approval for.

What are the discomforts and risks?

It is not anticipated that there will be risk of physical harm to any participants in the research. However, it is acknowledged that being a new graduate/novice clinician can be a stressful and busy time and there may be some emotional discomfort or stress caused when reflecting on this as a result of the focus group discussion. Also due to research taking place in a group setting means that complete anonymity/privacy cannot be guaranteed. Consent forms address and minimise these risks and ethical and professional obligation of confidentiality and privacy will be emphasised in the focus group setting as well.

While the study focuses on exploring the experiences of the participants on the programme, it is anticipated that feedback may also include critical views of the training provided. As part of avoiding harm to the reputation of the school, and ensuring any issues arising are addressed appropriately, constructive feedback along with any negative or critical feedback will be summarised, anonymised and provided to the Head of Department and the Head of School to be addressed as per department policy. Participants will not be disadvantaged in any way should they disclose this type of information. Participant confidentiality will be maintained through the use of de-identifying data, adhering to informed consent processes and the parameters outlined in this Information Form.

How will these discomforts and risks be alleviated?

It is not anticipated that there will be any clear risk of harm from participating in the research, however, in the unexpected circumstance that there is some discomfort, stress or unforeseen response to the focus group discussion, we offer some options for support below and would attempt to minimise any risks for all participants. If any issues have arisen directly as a result of participation in the research we would encourage you to access some of the free counselling services and supports available via telephone, text or online support.

Details of some available support options are listed below and more extensive lists and information can be found at https://www.health.govt.nz/search/results/free%20counselling on the Ministry of Health website.

- **Telephone/Text Support**
  - **Lifeline - 24/7 counselling by phone.** Lifeline provide free, confidential telephone counselling 24 hours a day, 7 days a week. Phone 0800 543 354 or www.lifeline.org.nz or Text HELP (4357)
  - **Need to Talk? Free call or text 1737 any time, 24 hours a day.** You'll get to talk to (or text with) a trained counsellor. This service is completely free. https://1737.org.nz. 1737 is part of the National Telehealth Service and can also be contacted on 09 354 7774.
  - **Youthline - Counselling & support for young people age 14-30.** Support is available on the phone, in person and via text. Phone 0800 376 633 or text 234. www.youthline.co.nz
- **Online Resources:**
  - **Mental Health Foundation of New Zealand** website provides nationwide information for accessing support and resources at https://www.mentalhealth.org.nz/get-help.
  - **All Right? Website** provides access information, support lines and resources for those in the Canterbury region. https://allright.org.nz.

Additionally a 'de-brief' session with the primary researcher will be offered to all participants following the focus groups should you wish to contact the researcher to discuss any aspect of the research or the focus group. These can be conducted either face-to-face or telephone support will be made available if more feasible. To further minimise risk of harm, de-identifying of all interview data will take place to protect your anonymity, and pseudonyms will be used if necessary to individuate an individual's response.

What are the benefits?

It is hoped you will benefit from participating in the research through reflecting on your experiences of being a NESP clinician, sharing stories of this and gaining a deeper understanding of how the programme has contributed to your professional journey and your competence and confidence as a clinician. Due to the research being submitted for a Masters qualification, you will be contributing to supporting my own professional journey, while sharing your knowledge and perceptions of the programme will contribute to current research, to a greater understanding the role of transition programmes for novice practitioners and the possible improvement in these important courses for future trainees.

How will my privacy be protected?

Due to the research taking place in a group setting, complete anonymity/privacy cannot be guaranteed. Consent forms address and minimise these risks and ethical and professional obligation of confidentiality and privacy will be emphasised in the focus group setting.

Researcher and research team will be aware of your demographic and professional details at the outset of the study. Identifiers will be removed from data when transcribed and confidentiality is guaranteed with the reporting of any findings. Pseudonyms/codes will be utilised when using any participant quotes as part of reporting findings.

Additionally, it is important that the privacy of consumers/patients/clients are also maintained and protected during the research. We would ask that any health information regarding consumers/patients/clients not be disclosed during focus groups without the individuals expressed consent, and that if examples of working with clients are discussed, then no identifying details are utilised and the anonymity and privacy of consumers/patients/clients be upheld.

What are the costs of participating in this research?

The cost to you taking part in this research is the time that you spend in the focus group interview (1-2 hours) and any travel time you may need to attend. As some participants will need to travel to attend the focus groups, a small koha of $30 petrol is offered to participants to facilitate travel and attendance at the focus group sessions.

What opportunity do I have to consider this invitation?

It would be appreciated if you could respond by email to this invitation within **one month** of the above date.

Will I receive feedback on the results of this research?

Yes. A two page summary of results and findings will be provided to all research participants at the completion of the project (approximately 2 years) and sent via email to the address that you were contacted on to participate in this study. Please update your details if they change over this period and you wish to receive copies of the findings. A full copy of the thesis report can also be requested.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor. Details are below.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 0064 9 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details: Suzanne Patterson. Email: Suzanne.Patterson@outlook.com. Contact: 09 921 9999

Project Supervisor Contact Details: Dr Ellen Nicholson. Email: Ellen.Nicholson@aut.ac.nz. Contact: 09 921 9999

Approved by the Auckland University of Technology Ethics Committee on 29.10.2018

Reference number 18/383

Appendix I: Participant Consent Form

Auckland University of Technology
Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999
www.aut.ac.nz

Consent Form - Focus Group

Project title: ***Novice Practitioners' Perceptions of Engaging in a Specialist Mental Health Transition to Practice Programme***

Project Supervisor: ***Dr Ellen Nicholson***

Researcher: ***Suzanne Patterson***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated October 2018.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.
- ○ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the focus group discussion of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 29th October 2018.

Reference number: 18/383

Note: The Participant should retain a copy of this form.

Appendix J: Participant Inclusion and Exclusion Criteria

Inclusion criteria: Participants were eligible to take part in this study if they:

1. Had successfully graduated from the AH NESP postgraduate mental health and addictions transition programme during academic years 2015-2017
2. Were logistically able to attend focus groups in main geographical centres of Christchurch or Auckland *OR* had internet connectivity to access a focus group meeting via online video conferencing technology
3. Provided written informed consent to take part in a focus group interview
4. Had sufficient English language skills to engage in focus group discussion

Exclusion criteria: Participants were ineligible to take part in this study if they were:

1. Trainees or graduates from other academic years of the programme including the 2018 academic year when this study was first proposed
2. Trainees who started but did not complete the full AH NESP programme during 2015-2017
3. Current transition programme students or those that had entered private, collegial, or professional supervisory relationships with the researcher since graduating from the transition programme

Appendix K: Pilot Group Interview Guide and Adjustments

Project title: ***Novice Practitioners' Perceptions of Engaging in a Specialist Mental Health and Addictions Transition to Practice Programme***

Pilot Questions

Tell me about your experience of being a NESP? What was the journey like? What things come to mind when you reflect on your experience? How do you feel now about the whole experience of being a trainee on the NESP new graduate programme? *Prompt:* What did it mean for you?
Adjustments: Simplified following feedback

The programme is intended to support novice practitioners to transition to MH & addictions practice – How did the programme do this? Or contribute to your development as a specialist mental health and addictions practitioner?

Adjustments: Removed following pilot testing. Feedback: Question too similar to opening question. When pilot tested gained similar information/content from participants or they commented that they had already discussed most of this within initial question

What were some of the positive experiences you had over the NESP year?

Adjustments: Altered following feedback to focus on transition programme: What has helped in the transition to clinical practice? How did aspects of the programme support this?

What were some of the barriers you encountered transitioning to practice/being part of the NESP Programme? What were the most challenging times/aspects/parts of the programme for you?

Adjustments: Simplified following feedback

I know you were asked questions in the end of year survey about how well the course met your professional development needs, so feel free to share those - but…were there surprising or any unexpected benefits/things that you gained/experienced from the programme?

Adjustments: Removed following pilot testing.

Are there other things the programme could do to better support the transition to MH practice for NESP trainees? Given your own experience as a NESP – If there was some advice you could offer novice trainees who were about to embark on the NESP programme – what would it be? And what advice would you want to give to programme providers/facilitators/managers?
Adjustments: Simplified following feedback

Notes (e.g. Themes Arising; difficulties with questions etc.).

……..

……..

Date: ……

Appendix L: Initial Interview Guide

Project title: ***Novice Practitioners' Perceptions of Engaging in a Specialist Mental Health and Addictions Transition to Practice Programme***

Focus Group # 1

Questions: Initial Guide

- What is it like being a novice practitioner on the Allied Health: NESP programme?
- What has helped in the transition to clinical practice?
- How did aspects of the programme support this?
- What were the challenges/barriers you encountered transitioning to practice?
- Are there any recommendations for changes you would like to suggest about the NESP programme?

Additional Themes to Discuss: (Member Verification)

……..

……..

……..

Themes Arising:

……..

……..

……..

Memos:

……..

……..

……..

Date: ……

Appendix M: Revised Interview Guide

Project title: ***Novice Practitioners' Perceptions of Engaging in a Specialist Mental Health and Addictions Transition to Practice Programme***

Focus Group: ZOOM

Questions informed by Krueger and Casey (2000).

- Thinking back, can you tell me what it was like being a NESP trainee?

  Reflecting on your experience of the programme – what was the experience like for you?

- What were some of the most positive aspects of the programme for you?

  Prompt: What helped in the transition to practice? Specifics of the programme?

- What were the biggest challenges you encountered in the transition programme?

  Prompt: How did the programme meet your professional development needs? Support your transition to practice?

- Are there any recommendations for changes – things the programme could do better? Recommendations for managers, programme providers you could suggest.

  - Any advice you could offer novice trainees that were about to start the programme?
  - Anything else you would have liked to have been asked about your experience as a NESP trainee?

Additional Themes to Discuss: (Member Verification)

……Peer support/connection; Lived experience perspective; Medical model v. recovery;

……Ongoing support – after the end of the programme?; Lived experience;

……..

Themes Arising:

……..

……..

……..

Memos:

……..

……..

Date: ……

Appendix N: Confidentiality Agreement – Transcriber

Auckland University of Technology
Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999
www.aut.ac.nz

Confidentiality Agreement

Project title: ***Novice Practitioners' Perceptions of Engaging in a Specialist Mental Health Transition to Practice Programme***

Project Supervisor: ***Dr Ellen Nicholson***

Researcher: ***Suzanne Patterson***

This confidentiality agreement pertains to services for transcribing focus group recordings between Shoba Nayar (transcriber) and Suzanne Patterson (researcher).

- ○ I understand that the information and content of the research project material provided for transcription is private and confidential and I agree to keep this information confidential and to not share this with any third parties.
- ○ Data and recordings will be kept securely whilst transcribing and third parties will not be allowed to access these.
- ○ I will not keep copies of the transcripts or recordings once our contract for services has been fulfilled and will return/dispose of these as per our agreement for providing this service.
- ○ I agree to only discuss the content of the recorded material with the researchers involved in the project, the details of whom are provided below.

Transcribers name and signature: Shoba Nayar .....

Transcribers contact details : email: snayar19@gmail.com .....

.....

.....

Date : 2.10.2019 .....

Project Supervisors Details :

Dr Ellen Nicholson

Email : Ellen.nicholson@aut.ac.nz

Phone : +64 9 921 9999 x 7742

Approved by the Auckland University of Technology Ethics Committee on 29.10.2018

Reference number 18/383

Note: The transcriber and researcher should both retain a copy of this form.

Appendix O: Example of Initial Groupings of Data

<table>
<tr><td colspan="4">First attempt at organising coding into themes</td></tr>
<tr><td>Theme 1.
‘Connection is Key’</td><td>Theme 2.
‘Peeking in Johari’s Window’</td><td>Theme 3.
‘There’s No Room at the Inn’</td><td>Theme 4.
‘Utopia of a Recovery Perspective’</td></tr>
<tr><td>Developing relationships occurs on many levels</td><td>Aristotle: ‘You don’t know what you don’t know’</td><td>‘The Reality’
‘Specialist Acute MH services have little space for applying recovery lens’</td><td>‘The Ideal’</td></tr>
<tr><td>Peers; Lecturers; with the service; with the wider system;</td><td>Knowledge acquisition is important
But it must be the right knowledge
(Undergrad prep?)</td><td colspan="2">Maybe collapse these Ideas?
A dialectic? Mutuality/binary? Dichotomy?
Recovery content</td></tr>
<tr><td>Data/Quote

And also being aware of all the service and providers that were available in not only in for CHCH for nationwide because you know we all have patients that are transferred and moving through and being able to know who to call and who to connect with in other areas was really beneficial and probably something I wouldn’t have looked into further if I hadn’t done NESP

I liked the um, yeah the group having the support and like having other people doing it and I think you know just being in NESP,

Connection was the biggest thing- shared experience; riding the emotional wave together

And I yeah can see the benefits of it like other people that say, um like meeting someone that doesn’t work at the DHB so they haven’t done um the NESP but they would think it would have been beneficial to them</td><td>Data/Quote
Our undergrad isn’t super MH focused so having that knowledge yourself that you were getting more knowledge around the areas that you needed was quite helpful.

I think NESP was really good to help with my confidence in that way because I was really unsure and mental health I mean we only touched on it, it’s only part of the programme so it’s not, it’s quite a specialised area so to have training specifically related to that I think was really good. To help with that confidence and being more sure of yourself
I still have my NESP resources but I don’t refer back to them anymore.

So having that in my third year was actually so good and just like reinforcing all like a lot of the skills or the things that I was already doing, or just like yeah reaffirming that it’s like okay I’m on the right track or it was like very good at like consolidating a lot of the stuff that, like through random interactions and trainings that I learned a lot in that first and second year but was good to like consolidate I think
I think there was very limited I mean in terms of social worker training it’s very general so we probably, there’s not a lot of specifics that we go into with mental health and addictions.

Actually one thing I’ve noticed and just recently we’ve had a new social worker start in our team and she’s um from Oranga</td><td>Data/Quote
to me it felt like there was no room to even think of recovery focus because it just felt like we were just pummelled everyday (laughter and agreement – yep) with all the different requirements that you are needing to complete and theres just task after task and before you know it you are just back at home trying to go to bed to get up and to do it all again.

I think um learning all that lovely recovery and strengths based focused stuff was great but then you had to come back to the reality for me working in an acute mental health ward, under the medical model mostly and um [right] um it was quite a contrast and it was kind of hard to implement some of those ideas and bringing them back to the ‘real world’. I found that quite tough.

There’s a little of disconnect about the actual theoretical stuff and how does it look in the practical sense.

It has been put aside – you have to tick the boxes and keep everybody happy. It’s too much energy and frustrating.</td><td>Data/Quote
you come in in your first year and you’re like real fresh and excited and like have all these ideas and then NESP like feeds that almost which is good but it like feeds that and especially like all these ideals around the recovery model and like it’s like it’s great that is the ideal world.

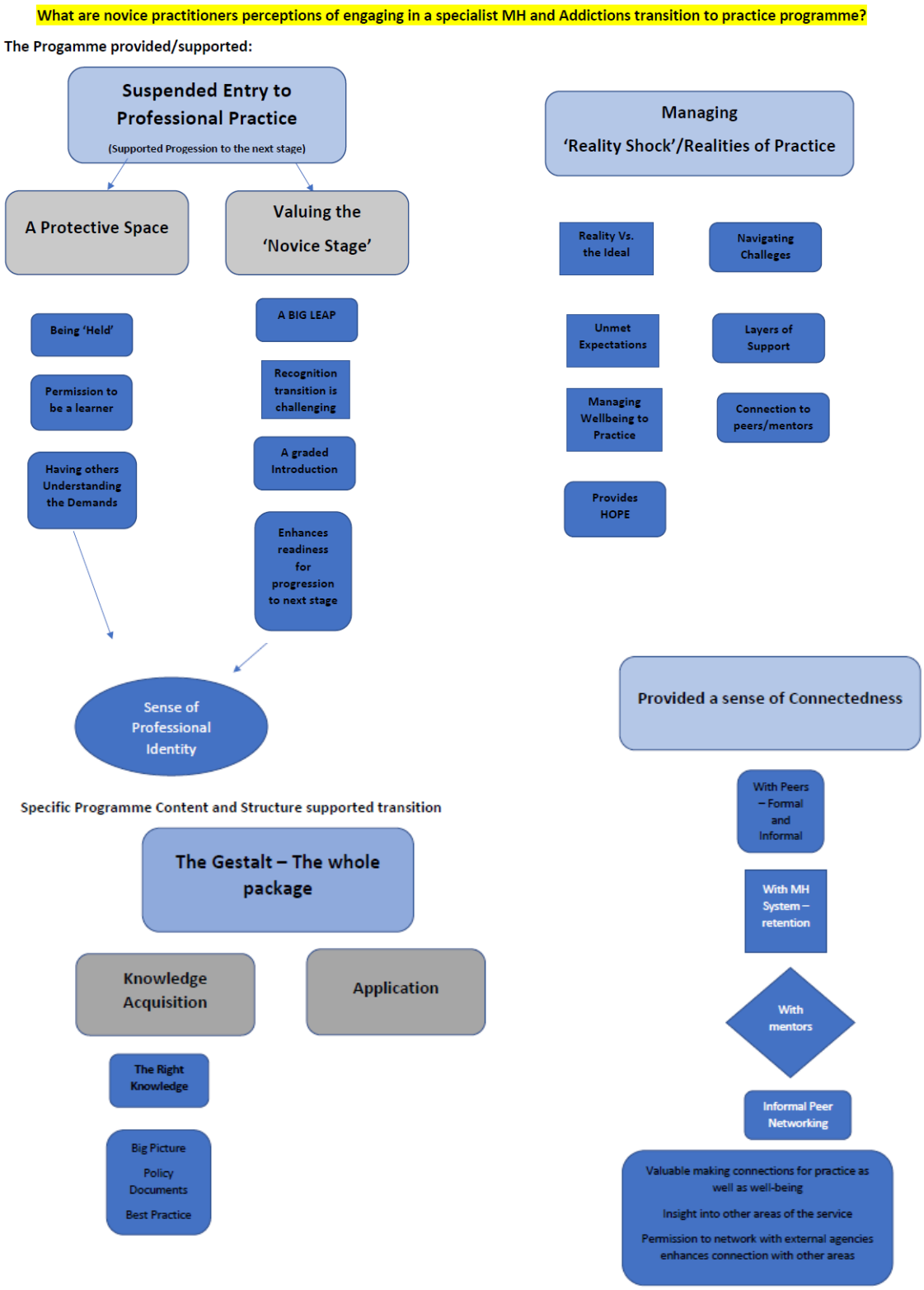
I think you can so easily get swept up in um I guess some of the established practices or more kind of cynical older clinicians and all that. So for me it was really useful to have that really strong foundation to come back so that you are building from a place that is really strong recovery focus rather than just getting sucked into the same ways that aren’t always as recovery focused.</td></tr>
</table>

	Tamariki and had other mental health experience but not specialist mental health and she asked me a question as we were talking about medications and this is one example is that, um, she said well how do you know this stuff? And I said well, and I actually said thinking back to NESP. I think if I perhaps didn't have that, how else would you sort of know I mean sure you pick up things on the job, but I think having that foundation as a starting point about medications because she didn't really have any idea.		
Coding - Camaraderie – You are in the same boat – in a group with like-minded people - Informal and formal peer supervision contribute positively to experience - Relationships are built over NESP and cemented through shared experience, going through the same things at the same time (the stress of assignments; the highs and lows; the new learning together) - Relationships continue after the learning has stopped. - Forged ongoing relationships with people with similar ideas and mindset. Extends beyond the course - I am not alone – there are others having the same experience as I am – Hearing others stories normalised own experience - connect quicker to the service and other practitioners when in the programme - Managed learning space allowed for connection and created a learning culture Being held and acknowledged – you are not on your own Connection supported wellbeing.	Coding - Aristotle 'You don't know what you don't know' - It's all novel knowledge - Developed understanding of core elements of practice that was previously unaware of. - Becoming aware of knowledge that was gained – even if on an unconscious level - Gaining specific, relevant MH knowledge is important; confident you were learning the 'right' things Academic content was important. Resources were important Knowledge gained forms scaffolding and building blocks. - Knowledge also becomes more second nature and embedded in practice and perspective. Helps combat imposter syndrome I have knowledge and know about things that other new graduates do not Supports Development of Clinical reasoning 'Checking out' knowledge and growing specific MH knowledge was valued. Found a niche for sharing own knowledge to support others 'Forced' (or expectations to) apply new learning and gain experiential understandings increases the curve of the learning Knowledge allows you to question the system – not just maintain the status quo	Coding - Mismatch between current practice and the recovery lens. - Practice is systems dependent and answers to this rather than the needs of consumers. - Old ways of practice are established and don't include recovery knowledge - 'Responsible Subversion' - Easier to fall in line Hard to challenge the 'master narrative' Pantene – it might not happen overnight, but it does happen. Systemic pressure limits opportunities for recovery focused practice – focus on basic needs rather than aspirational meaningful goals. Feeling helpless to implement despite having the desire to do so focus on basic needs rather than aspirational meaningful goals. System does not support the learning – still have to do the requirements of MH system rather than working from perspective of the consumer	Coding - Learning re: recovery fits well with personal and professional values - Focus of the paper supported own values Exposure to ideals early on in practice is useful Trying to keep focused on a 'better way' of practicing Strong professional and recovery leaders show the way. Role models are powerful motivators Its ideal (is it unachievable and setting clinicians up for failure?). Removed from actual practice - how will this ever be possible?
Theme 5. **It's the Whole Package 'The Gestalt'**	Theme 6. **Graded Transition to Role of Health Professional**	Theme 7. **'?Parallel Process' – C.H.I.M.E. (more latent)**	Theme 8. **Establishing professional Identity**
The programme gives you so	'Protected introduction to	Clinicians are gaining from the	Doing, being, becoming,

much more than just the knowledge. Its more than the sum of its parts.	role'. There are benefits to being a NESP trainee. Include theme 11?	programme what consumers want from the MH system	belonging ?OT Theory
Data/Quote: I don't think it would have been meaningful at all to just do it as a programme without work. Cos you just don't have the coat hanger to hang any understanding on. But it was the whole package, you needed to have that work in there as well as doing the study and reflecting to have that with a service or it wouldn't have been that beneficial. You can help [other new graduates] but the in-depth stuff needs to be taught from someone.	Data/Quote: like I said if I'd sort of been chucked in the deep end I might have had different sort of experience of mental health, sort of being guided in slowly sort of um yeah. Exposed I guess. Really helpful yeah so it was really making sense of myself as a social worker and what I needed to be doing and I think there was very limited I mean in terms of social worker training it's very general so we probably, there's not a lot of specifics that we go into with mental health and addictions but like I just felt like I was they were so much more supported and I think it was just like and even in like having like thresholds for like how many people you pick up and a caseload to manage and things like that like I ended up being given a lot more than they did and even and another thing I noticed was they were a lot more, like a lot better connected in with like other service and other people than I was.	Links to Connection, Hope, Identity, Meaning and Empowerment Connection was the biggest thing riding the emotional wave together Having people come in and talk about how they've gotten through that, sort of gives you hope as well So, it does happen guys. It might not happen in a district health board [but] it can happen	Data/Quote: It made me kind of reflect on what and how I was practising and what it means to be an OT to be working in MH. And I it did stay with me. I mean That ability to step back and look at the bigger picture and bring it to practice. You know what am I doing as an OT in this role? (Yeah) I am in a generic role now so I have to really think quite often about how I bring an OT perspective to what I am doing. so it was really making sense of myself as a social worker and what I needed to be doing Reflecting on your practice you know (yep) instead of just doing it and actually thinking about where am I coming from and why am I doing it this way **I think well for me when I did NESP, it was my first year of practice so I think you know I was kind of feeling my way through it and um, just trying to figure out what being an OT is all about**
Coding Comments Programme was well structured to allow for acquisition or new knowledge, applying in clinical arena and reflecting deeply on practice. Order of the learning is important – MH Practice and then recovery. Knowledge is power – You start to understand the language It's the structure – the pace of learning Structure of programme supports transition Supervision and study days provided layered levels of support NESP provides ideas for how to practice – it is more than just knowledge. The programme allowed space and time for integrating ideas – it energized people for practice Understand other areas of MH practice Understand the wider MH system – The Big picture.	Coding Comments There are benefits to being a NESP trainee. It is a graded transition – not expected to be fully fledged MH worker from the start. It was a transformational process Practical level – caseloads are capped; additional support from mentor/preceptor; connect quicker to the service and other practitioners Bridging the Gap Others have to do it on their own – figure out the system without help Intensive learning curve. 'Forced' (or expectations to) apply new learning and gain experiential understandings increases the curve of the learning Being gently supported to grow Not thrown in the deep end.	Coding Comments Meaning making - Existential questions are raised re: what it means to be an OT. Shining a professional lens to practice. Meaning and understanding are enhanced by variety of learning experiences – applied learning makes sense Developing advocacy skills for self – empowerment. Connection supported wellbeing Post graduate study was meaningful Hope for change	Coding Comments Recognition of recovery content paralleling own values and principles Professional identity strengthened through reflection and redirection to professional foundations A time to strengthen professional foundations and what it means to be an OT/SW working in MH. Own professional knowledge and Identity were strengthened hearing from other disciplines and what their roles are. Supported the gradual adoption of a professional identity/identity – role acquisition.

Theme 9. **Understanding Lived Experience is Crucial**	Theme 10. **Rollercoaster of Emotions and challenges**	Theme 11. **Support**	Theme 12. **Self-care and Well-being Felt Compromised.**
The Irony of it All	Tensions: Throw away? Collapse with self-care?	There are many layers of support provided	???
Data/Quote: I think I don't think I expected there to be such a strong focus on um what people's experiences were like. But for me that ended up being one of the most helpful things I loved doing NESP. I enjoyed learning what I learnt its highlighted how important it is to acknowledge peoples journey and their experience and you know it's really put that client-centred focus on and I know that I that they have to lead me (47mins) being able to actually sit down and listen to them it aligns so much with what social work is. You know you home in on the person and what's around them and what they want and that's what I felt it really reinforced my training [great] and its yeah. It's my foundations and they all align together and it actually made it easy to do what I do and it's just the system that trips me up a bit.	Data/Quote: Its one of the hardest things I've ever done. I was exhausted all of that year I wanted to quit I loved it… I thrived off doing it and I loved meeting the people that I did and loved learning the new things that I was learning	Data/Quote: So, I kind of kind of got left on my own and was given a case load and was thinking 'oh my god I don't know what to do' – so it was pretty intense that my first (NESP) placement. But because of the support I had around me it really helped me get through it Watching other NESP's - but like I just felt like I was they were so much more supported and I think it was just like and even in like having like thresholds for like how many people you pick up and a caseload to manage and things like that like I ended up being given a lot more than they did and even and another thing I noticed was they were a lot more, like a lot better connected in with like other service and other people than I was.	Data/Quote: I found that it was probably one of the hardest things that I have done cos I've got 3 children and trying to do the full-time work and manage life with that I I honestly… there were times that I contemplated quitting
Aligning with Values/importance of focusing on client lens. Clinical practice is easy when you actually focus on the client – everything clicks into place (when you get the focus right) Fits personal and professional philosophies	It was hard – but there was a sense of accomplishment at the end Emotional process Exhausting Gave purpose Content was motivating – spurred on Cost-benefit ratio supports doing the course. Range of emotions and feelings Valued/needed but hard work – different from expectations Reality shock Negative attitudes of colleagues The tide of old ways Cynical older clinicians Recovery not welcomed Responsible subversion Practice is not ready for this Seeing a vision of future service provision	Coding Having someone on your side Protected within the services/with workload Pastoral Care was important Peer support was valued Preceptorship role is important someone who was aware of your needs as a new practitioner Parallel process with LT services supporting clients and NESP – support/wraparound/we hold people. Found a niche for sharing own knowledge to support others	Coding NESP takes a toll on you but you develop resilience and manage it somehow. View that its beneficial but challenges you. It is all encompassing. NO room for other things. importance of wellbeing is amplified; Aware self-care being ignored. Life gets taken over with study(assignments) View that there should be time made within balance of work life Can't get away from MH when a trainee – constantly have head full of MH. Home life was affected – personal challenge Wellness plan – using in other roles with students, supervisees, clients – super valuable.

Appendix P: Initial Theme Diagramming



Appendix Q: Thematic Analysis Checklist

Processes	Steps taken to ensure quality of thematic analysis
Transcription	• Focus group recordings have been listened to repeatedly • Focus good recordings have been transcribed (by transcriber and researcher) in detail and compared against audio-recordings to ensure accuracy. • Transcripts were reviewed numerous times.
Coding	• All excerpts across the entire data set were coded and re-coded over several coding rounds to ensure coding was thorough and comprehensive. • Codes were constructed from the data and were not pre-determined. • Attending coding workshop supported coding processes. • Collated codes were organised into preliminary themes which were constantly compared to the original data set. • Themes were checked against each other to ensure they were consistent with the data, distinct from each other and were internally coherent. • Coding and theme generation processes were robustly reviewed within research supervision.
Analysis	• Interpretation was part of data analysis processes and this thesis used data excerpts to illustrate any interpretations made.
Overall	• Significant time was spent on each stage of the thematic analysis including returning to data set numerous times to re-code, review and progress findings and understanding of the data. • Re-immersion in the data, repeating analysis processes following a significant break from the research process supported depth of analysis.
Written Report	• Interpretive descriptions epistemological, ontological and philosophical assumptions are detailed within methodology. • Data collection and analysis methods are consistent with an interpretive description approach and the language is congruent with interpretive description methodology. • Themes were constructed from the data during data analysis by the analytic processes employed by the researcher – this positioned the researcher as active throughout data analysis processes. Even if discussed as emerging – this was because of analytic processes researcher undertook.

Adapted from *Using thematic analysis in psychology* by Braun V. & Clarke V., 2006. From: Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. doi: 10.1191/1478088706qp063oa