Project Report

An evaluation of a primary school service learning model among health students

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Background

Health has emerged to mean more than the absence of disease (WHO, 1978), but encompasses “complete physical, mental and social well-being... [and] a resource for everyday life”(WHO, 1986, p. 1). Over the past four decades, there have been many changes in health and social care with a major shift in thinking around health. There is a greater emphasis on individual and community wellbeing through health promotion. One example is the cultural shift to reduce sun exposure that was propelled through media campaigns, education within workplaces, schools and the wider community (Borland, 1990; Dobbinson et al., 2008; Randle, 1997).

With this advancement of health and health care moving beyond the walls of the hospital setting, it has been essential for many health professionals to develop knowledge, skills and competence in a way that meets the evolving health care needs within the community (Clarke, Martin, Sadlo, & de-Visser, 2014). Despite this, the bulk of placements for health programs remain within the hospital setting. Unfortunately, the realities of working in health are that much of the health care provision occurs outside of the hospital setting, due to health reforms and changing work practise, which suggests current education practices inadequately prepare graduates to be work ready (Bossers, Cook, Polatajko, & Laine, 1997; Mannix, Faga, Beale, & Jackson, 2006; Overton, Clark, & Thomas, 2009). In addition, there continues to be a shortage of education placements in hospital settings for student health professionals, and this will continue to be exacerbated with greater health student intakes occurring (Aiken, Menaker, & Barsky, 2001; Casares, Bradley, Jaffe, & Lee, 2003; Huddleston, 1999; Overton et al., 2009).

Huddleston (1999) has argued that educators are not looking in the right places for quality clinical placements that will adequately prepare health care students to be ‘fit for practice’ or have the capacity to work in challenging and ever changing health care environments. As such, a shift away from the more ‘traditional’ practice placement models to more ‘non-traditional’ models has occurred, particularly among allied health disciplines. However, limited research has been conducted on many of these non-traditional placements (Lekkas et al., 2007; Overton et al., 2009).

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Despite this lack of research, what has been noted is that non-traditional practice placements provide students with real-life workplace experiences. These placements extend student learning and facilitate the development of clinical skills, professional behaviours, reasoning and competence that is required for future practice when interacting with individuals, families and other health professionals (Daly, Roberts, Kumar, & Perkins, 2013; Overton et al., 2009; Worley, Prideaux, Strasser, Magarey, & March, 2006).

Overview of current models

Non-traditional practice settings were first discussed in the 1970s and used particularly among occupational therapy and social work students (Overton et al., 2009). However, with the expansion of the movement for alternative or non-traditional placements, there is an ever-increasing discussion and taxonomy of practice placement models (Lekkas et al., 2007; Prigg & Mackenzie, 2002).

Lekkas et al. (2007), in their systematic review of which non-traditional model was most suitable for clinical placement, identified six broad practice placement models among undergraduate allied health disciplines. It must be noted, the review was unable to effectively identify any one model that was better than the other. In most cases, a suitable model was dependant on the discipline, setting and learning needs of the student. Nevertheless, the models included:

1. one-educator-to-one-student model;
2. one-educator-to-multiple-students model;
3. multiple-educators-to-one-student model;
4. multiple educators-to-multiple-students model;
5. student-as-educator model; and
6. non-discipline-specific-educator model.

The focus of our discussion is the sixth, non-discipline-specific-educator model, which has a varied number of titles within the literature. This difference in nomenclature is at times dependent upon the discipline and setting where the placement takes place (Dunbar, Simhoni, & Andersen, 2002; Overton et al., 2009). The list of titles is not exhaustive, but for

the purpose of this report the term 'service learning placement' will be used synonymously with any of the terms that may include:

- Participatory community practice placement;
- Community based fieldwork;
- Independent community placement;
- Field immersion placement;
- Non-traditional placement
- Innovative placement;
- Self-directed 'practica'; and
- Role-emerging placement.

Despite the differences in nomenclature among service learning placements, what has been highlighted is that these similar models share common aims and objectives. These include working independently and working in pairs or teams with limited on-site or off-site supervision by a discipline specific and/or non-discipline specific supervisor (Lekkas et al., 2007; Overton et al., 2009; Stainsby & Bannigan, 2012). In addition, the student or students completing a project, such as developing a community-based programme to address a need that has been identified in collaboration with the organisation where the placement is taking place (Overton et al., 2009; Prigg & Mackenzie, 2002).

The advantages of this model are that it has been indicated to develop the professional growth of the student through an autonomous learning experience. The opportunity has the potential to facilitate group learning, collaboration, intra-professional communication and collaboration. In addition, students experience how the discipline functions within the community setting, while developing their professional identity (Clarke et al., 2014; Lekkas et al., 2007). Further, other research suggests the model provides students

> ...with an opportunity to challenge what they had previously taken for granted and to arrive at new perspectives and understandings, creating an awareness of change in their development of personal and professional self, vision, and understanding of the profession. (Clarke et al., 2014, p. 226)

The challenge is the model has a number of disadvantages, such as the students' perception that the placement does not provide adequate grounding in practice and can cultivate a sense of fragmentation among student. Further, establishing, planning and monitoring

service learning placements is time-consuming and costly to those implementing the placements (Clarke et al., 2014; Lekkas et al., 2007).

The organisations where placements have taken place have been wider and more varied than the names used to describe service learning placements themselves. They have included community agencies, home care and aged care settings, day centres, urban senior centres, rural and remote settings, private practices, disability centres, shopping centres and childcare centres (Lekkas et al., 2007). In addition, other placement settings have included education organisations such as schools.

Health placements in schools

School placements have been shown to be both beneficial for the school and for the health care students (Splett & Maras, 2011). Papa, Rector, and Stone (1998, p. 415) have reiterated that "health and education are inextricably intertwined, and that efforts to improve school performance without addressing health are as ill-conceived as focusing on improving health while ignoring education." As such, schools, as a service, have the potential to create the opportunity for health care to be provided in a way that creates greater health access, prevention and early identification of health issues, particularly among those who may not normally have access to or seek health services (Dunbar et al., 2002; Splett & Maras, 2011). The health care student placement within the schools may also allow 'services' to be provided to schools that may not otherwise be able to afford such services (Bakken, 1996).

Through these processes, principals and teachers have the capacity to be interdisciplinary or interprofessional collaborative partners with universities, academics and health professionals to develop the professional practice of health care students. It also allows health care students to raise the profile of the discipline, augment the professional development of teachers, support parents and assist schools to refocus child health and well being to enhance overall education (Bakken, 1996; Dryfoos, 2002; Dunbar et al., 2002; Thew, Hargreaves, & Cronin-Davis, 2008). However for this synergistic relationship to develop and continue, there needs to be a shared ownership regarding decision making, planning and action (Salm, 2010).

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Shepparton service learning placement

The service learning model used in Shepparton has similarities to models that have been used within the Broken Hill UDRH. The Broken Hill model indicated that students learned significantly on their placement, became work ready and felt valued because they provided 'clients' with care they would otherwise not receive (Daly et al., 2013; Lyle et al., 2006).

The Shepparton service learning model provided opportunities for allied health students to be placed in local primary schools. In the school setting, the allied health students were supervised under 'long arm supervision' (Kabli, Liu, Seifert, & Arnot, 2013). This model was used so that students were able to broaden their interpretation of health and health care, while developing their interdisciplinary training experiences through collaboration with teachers, aides and potentially other allied health professionals within the school setting (Cooksey et al., 1995; Guion, Mishoe, Taft, & Campbell, 2006; Kabli et al., 2013; Thomas & Texidor, 1987).

These opportunities were developed to allow student to explore the role they can play as health professionals and to learn by doing the practice of their field. It was also implemented so that the primary school's pupils may be able to benefit from the allied health students' practice (Gill et al., 2011; Smith, 2014; Woodley & Fisher, 2013).

The framework of the Shepparton service learning model is similar to that which is outlined by Solomon and Jung (2006, p. 60), and one that has been adopted internationally, (Stainsby & Bannigan, 2012), in that sites:

1. [do] not have an established programme or a staff person hired to fill the role;
2. is coordinated and supervised by an off-site licensed therapist who is not employed by the setting; and
3. has students assigned to a site staff person as a contact for site concerns.

However, the Shepparton service learning model differed slightly in that supervision across the sites was provided using a mix of non-discipline and discipline-specific staff that were in most cases offsite for the duration of the placement (Lekkas et al., 2007). Direct contact with a discipline specific educator took place weekly, where practice was modelled and additional clinical education and assessment could take place (Solomon & Jung, 2006;

Stainsby & Bannigan, 2012). In addition, offsite clinicians from a different discipline (school nurse) familiar with the school were employed and assigned to each group of students to be the support person. Lastly, a co-coordinator was employed to act the key collaborator and negotiator with schools, clinicians and students.

Students were place into groups, to be supportive to each other and provide opportunity for peer learning. Peer learning has been suggested to promote reflection, self-direction and deep learning (Lincoln & McAllister, 1993, p. 19). The role of the group was also to facilitate greater self-directed learning, management of projects and working with identified children. The process also allowed group discussion, group learning and problem solving in order answers to key questions that may have arisen (Bogo, Globerman, & Sussman, 2004; Dancza et al., 2013; Mason, 1998; Stainsby & Bannigan, 2012).

Students were allocated to be in schools for their 5 week placement for 4 days a week while 1 day was dedicated for administration, skill development, meeting with placement coordinator and developing and completing placement objectives as outlined by the student's education provider.

Conclusion

Providing the opportunity for students learn more autonomously through a service learning model allows knowledge and skills to be developed, while encouraging students to progress towards the development of their professional way of being (Clarke et al., 2014, p. 227) There has been much discussion concerning the efficacy of such placements as an innovative alternative in that it prepares health care students to meet the demands of practice; however there is some conjecture concerning the overall value of such programs. It has been argued that there is a need to continue to examine service learning models to provide a greater evidence base as to their effectiveness to prepare graduates for the workplace and particularly what impact they have on the non-traditional placement organisations such as schools (Bossers et al., 1997; Clarke et al., 2014; Thew et al., 2008). Few studies have examined service learning in Australian settings and there remains little direction regarding what is the most appropriate model of clinical education (Lekkas et al., 2007; Solomon & Jung, 2006).

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Methods

This project sought to evaluate the service learning model that is 'new' to the University of Melbourne, UDRH. The service model provided opportunities for allied health students, such as physiotherapy students, to be placed in two primary schools in Shepparton with a high proportion of students from disadvantaged backgrounds. The allied health students were under 'long arm' supervision and were to find their own case loads. While this is a small project, the results from this exploratory project with the first cohort of students will help to improve future placements and innovative placement learning models. It will also contribute to the service learning literature in rural Australia.

Research aim

This project aimed to understand the student placement experience, while examining the efficacy, benefits and challenges of the pilot program. This was achieved through an evaluation of the service learning model from the students', teachers', principals' and co-ordinator's perspectives. Each of the participants provided an array of differing viewpoints, perspectives and thoughts that provides insight into the model's usefulness, existing inefficiencies, and the long term value.

Significance

The evaluation of this particular student placement sought student experiences, student learning and transition into schools. The process of developing the placements, participation in the school and outcomes for the school were also assessed. As this was the first cohort of students in this model, areas for improvement were be explored. The evaluation provides an understanding of the allied health student's perspective and learning outcomes from the placement for the universities and schools involved.

Setting

Students were placed in primary schools with a high number of disadvantaged students. The focus was intervention for those primary school children who would not otherwise meet external funding parameters to address their health need. Allied health students were

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well placed to provide early intervention to primary school pupils and to improve health outcomes by developing management plans for each school.

Data collection

The project received approval from the Rural Health Academic Centre Human Ethics Advisory Group. To achieve the aims of the study, data collection was conducted by a researcher at the Department of Rural Health between October and December 2015. Data were collected from participants using the following methods:

1. focus groups with the same 6 fourth (final) year physiotherapy students occurred on 3 separate occasions for the duration of the 5 week placement, on day 1 of week 1, day 5 of week 3 and day 5 of week 5;
2. semi-structured interviews were conducted with four school staff including principals and teachers from both primary schools; and
3. semi-structured interviews were conducted with the project co-ordinator and two support staff of the service learning model.

A total of three focus groups of six participants each and seven interviews were conducted. Each participant was invited to voluntary participate in the evaluation by participating in a focus group, face-to-face or telephone interview.

Data analysis

All interviews and focus groups were audio-recorded and transcribed into Microsoft word files. All transcripts were read to identify themes for analysis. Transcripts were then coded and a discussion of each theme is presented below. A number of quotations were included in the report to illustrate and support the accounts emerging from the textual responses. Participants were coded on the basis of their role such as student, school staff and support staff. Likewise, information concerning the focus group order (1, 2 and 3) was used to code the data of the Physiotherapy students.

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Results

There were a number of key findings that emerged from the interviews with school staff, support staff and the focus groups with the physiotherapy students. The findings comprised of what students anticipated and experienced within the service learning model and what benefits were gained among students, teachers and primary school pupils. Also identified were a number of modifiable challenges that, if addressed, may potentially improve the current service learning model. Each theme is discussed in detail.

Choice of placement

Among the six students, it was indicated that three had selected the primary school placement as one of their preferences. This preference was based on proximity to home and the ease of going home on the weekend, rather than placement experience and potential learning outcomes. However, among these three students one indicated they had an interest in paediatric physiotherapy, another stated they were interested in rural practice and the third thought the placement would be “different and interesting” (Student, FG1). The remaining three students had not selected the placement as a preference; two specifically did not as it was between 5 to 10 hours from home. Nevertheless, they had been allocated to undertake their placement at one of the primary schools in Shepparton. Although it was an unexpected and felt to be an unorthodox placement, the student who had travelled the furthest expressed their excitement once they had arrived.

Receiving information prior to placement

Each of the students highlighted they had not received adequate information prior to commencing the placement and this had heightened their anxiety. Students felt they were inadequately prepared for their placement, how the placement would ‘work’ or even what role physiotherapists actually played in primary schools. At the first focus group, a student asked, “Why is a physio going to a primary school?” Another student stated “I had to look up what a physio does in a primary school”, while another said “all the textbooks that we were prescribed... didn’t have any bearing to what we are actually going to do and there was no articles that I could find.”

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It was suggested by students and support staff that more students would opt to undertake a primary school placement if greater information was provided at the time of selecting placement preferences. Students felt that primary school placements would need to be 'sold' more effectively with greater detail, as hospital placements were more highly sought after than relatively unknown placements. Prior knowledge of the primary school placement and what to expect was highlighted to impact the confidence in the placement and also those providing the placement. Three students, after receiving orientation on the first day, said they were excited about the placement and happy to see how enthusiastic the schools were.

An additional topic that permeated all three focus group discussions was how student assessments were to be conducted and how assessments were to be adapted to adequately assess student performance and competence. Although not directly related to being prepared for the placement itself, students felt the uncertainty of being assessed in a primary school environment had an impact on their overall performance.

The information concerning assessment was not adequately articulated to the students and was said to cause a lot of undue fear, stress and anxiety. This anxiety was particularly evident among students who had 'unconventional' placements previously and where the assessment was felt not to reflect a student's overall performance.

Expectation and outcomes of the service learning model

Skill development

Prior to commencing their placement, student's expectations regarding the placement were brief and ambiguous. This may be reflective of the lack of information concerning the placement and highlights that "none of them had any idea what they were getting into really" (Support staff). It was suggested by other support staff that the benefits of undertaking a primary school placement were not always as easily identified for students, which may have impacted their views regarding the efficacy of the program.

Despite the benefits not being easily identified, students suggested they would learn how to communicate, build rapport and work with the primary school children; to work with and educate 'non-health professionals' regarding what a physiotherapist is and actually does.

Notwithstanding, there were concerns and fears among student regarding the lack of 'acute' learning opportunities to gain specific clinical skills while on placement. A student said:

> *I think [the school placement] is a great idea, but I'm just worried that we might not develop physio specific skills as much as some of the other placements. (Student, FG1)*

Communication and interprofessional skills were suggested to be developed within the placement; however there was a mindset that without frequent or direct supervision, every last opportunity to develop clinical physiotherapy skills would place students at a disadvantage. One of the support staff stated "there's a couple that... would have liked to have spent their last placement in a hospital so they can hone all their skills". This was echoed among other students who stated without acute care setting exposure new skills could not be developed. This suggests the primary school placement may challenge student expectations of what skills will be learned and also their capacity how to 'act' as a physiotherapist when not in an acute clinical environments.

Mid-way through the placement, the expectations among students had shifted focus to be more concerned with developing professional skills and what made a 'good' physiotherapist. It was suggested that the physiotherapy students were initially hesitant, yet by the second or third week of placement "they said oh, we're starting to see the picture now" (Support staff). This was reiterated when two students said

> *I think [the placement is] more about developing your professional skills rather than like your physio skills, like communication, that's been really tested but I think it's improved. (Student, FG2)*

> *I think [this placement] makes you more prepared and probably a better therapist as a result. (Student, FG2)*

However at the end of the placement, the discussion had shifted again to the disadvantage of the placement in terms of not having adequate opportunity to develop skills. The discussion had moved back to an acute care clinical focus, where much of the conversation was concerning skill development, present at the initial focus group discussion. In the first and last focus groups, there was an association between skill development and having adequate acute care exposure. Three students indicated:

> *If I work in a practice and I have some paediatric clients... I'm not going to be prepared for that because... I've only seen 'normal'. (Student, FG3)*
>
> *I do understand the objective of getting allied health input into schools, which I think in theory's a great idea, but in terms of a learning experience I don't know how beneficial it is. (Student, FG3)*
>
> *I mean you can always learn your professional skills later... you could develop it working in a shop. What you can't develop is your assessments skills and your discipline specific skills, which I think is something that we kind of missed out on. (Student, FG3)*

It is difficult to ascertain why there was a shift from acute care and clinical skills development to broad professional skills development and then back to acute care and clinical skills throughout the placement period. This may be reflective of the fact that a number of students had received or were waiting for confirmation of acute care employment at the time of the third focus group.

Despite this finding, one student highlighted they were fully cognisant of what the placement was about and what they had learned, while another student suggested the school placement allowed them to work more independently and prepared them for practice, when they said:

> *[It] was self-directed; it wasn't so much about the outcome, as the process... and being completely autonomous... We weren't told anything to do, we had to get there and negotiate what we wanted to do and sort of think of our own programs, think of our own stuff... It was a blank canvas which I think was a lot different to getting to a hospital and going here's your list go do it, I'll be watching... which I actually liked, but it was different. (Student, FG3)*
>
> *It's our capstone placement - our final placement. So in a way it's good to be... independent we're... working out who we're going to see, when we're going to see them... it's kind of more like the real world in a way. (Student, FG2)*

Both school and support staff indicated physiotherapy students had developed a greater number of life skills while on placement. These included, collaborating and communicating with children, parents, different disciplines and diverse cultures outside of the hospital setting. These experiences were felt to prepare students more for employment in the "real world" (School staff). However, it was suggested that many of the students may have been

unable to identify what they had developed beyond clinical skills alone. In particular one support staff member stated:

> *I don't think they necessarily made the connection that... a really independent motivated worker is a commodity and they haven't quite seen that this placement perhaps gave them those skills... (Support staff)*

> *Once they've had a chance to work, then I think they'll look back on this placement and... see more value in it than they maybe did at the end of that time. (Support staff)*

> *I could hear a lot more learning about working with different professionals... stuff around inter-professional learning and their own growth which I think they missed, they could verbalise it... but I don't know that they necessarily identified it. (Support staff)*

Working with education staff

Among students, there was an expectation that interdisciplinary collaboration would occur, in that teachers would flag potential primary school children to further assess and that the physiotherapy students would learn by working with teachers. Although this did occur, the physiotherapy students felt there could have been more preparation and communication from the school regarding which primary school children required the most help. Similarly, teachers suggested that physiotherapy students needed to communicate more effectively in terms of what they were doing with the children while providing greater feedback regarding those children they were working with. Despite this, one group of physiotherapy students were described as insightful, resourceful and encouraged teachers early to list their concerns and identify children who may need the greatest help and then provided feedback and strategies for teachers to assist the children.

Physiotherapy students also highlighted that when first coming to the school, teachers needed to be educated around the role and function of a physiotherapist, as there was confusion regarding the difference between an occupational therapist and a physiotherapist. In many instances teachers would highlight occupational therapy concerns, such as hand writing, which was out of the physiotherapy student's scope of practice. This confusion of roles between occupational therapy and physiotherapy remained evident after student placements were completed as two students stated:

I think there's still some misunderstanding about what we were doing there. (Student, FG3)

They do not understand the role of physio and what we were doing. (Student, FG3)

It was suggested it would be beneficial when the physiotherapy students first arrive at the school to have a 'meet and greet' or short presentation with the school staff as "it took them a little while to figure out what the physio students were actually there for" (Support staff). Despite the confusion of roles, programs and activities were implemented that were within the physiotherapy student's scope of practice, such as the Happy Hands program. This activity was undertaken as physiotherapy students did not want the identified occupational therapy issues completely unaddressed.

Teachers were on the most part receptive to the physiotherapy students and in most cases the students were considered to be professionals in their field. It was stated that many teachers saw them as professionals with professional knowledge rather than students as "they looked like they were ready to go straight into practice" (School staff). However, it was believed some teachers did not show professional courtesy towards students, would not allow a primary school pupil to be taken out of class for an assessment, or did not want to undertake physiotherapy-led class activities.

Two support staff members indicated that teachers may have been more hesitant than difficult, stating "often teachers don't like having student teachers, let alone some other student that I've got to keep an eye on" (Support staff). However, a student stated "there have been a few other instances where... I personally feel like I've been made to feel like a hindrance to [the teachers]" (Student, FG2). Although this was only a few select teachers, this may be reflective of their lack of awareness regarding the role and function of a physiotherapist, and in what capacity they could be used within the school or classroom.

Students suspected teacher behaviours and attitudes may be due to the perceived worth of the program or the disruption the physiotherapy student may have on class time or on primary school pupils. Alternatively, other students sensed teacher reactions and attitudes were due to not being adequately prepared for what to expect when physiotherapy students were the classrooms. One support staff stated that if teachers felt the physiotherapy students were adding value to the children and the classroom, then the teachers would engage with the program more. This was further illustrated when, students

indicated that once they were able to demonstrate what impact they can have with primary school children, they were able engage with and assist the teacher's understanding and practices. For example, a student and two school staff members stated:

> *I sat down with my teacher a few times... I was able to talk to her about... the concept of gross to fine motor development, cross body movement developing the connection between the two hemispheres which she took on board. I think that's impacted her practise, but also her understanding of why it's important to do gross motor development. (Student, FG2)*

> *I would suggest that everything that [physiotherapy students] did was well received by our staff, our staff were really enthusiastic about it and loved having them in the classroom. (School staff)*

> *The teachers were really positive about the experience... they felt like it was a good learning experience for them as well. (School staff)*

Sustainable resources after placement

Among students there was a realisation that the placement period would be short. Both physiotherapy students and school principals were concerned about the sustainability of the primary school service learning model once students had completed their placement. Although not well articulated within the initial focus group, there was discussion concerning the need to educate teachers by providing background, justification and reasoning behind why certain programs are used. Further, it was highlighted by principals and physiotherapy students that developing and leaving a sustainable resource for teachers to utilise for future reference was vital. Throughout the placement, key resources were developed to ensure the sustainability of the work the physiotherapy students were undertaking.

Key resources were developed to assist teachers to assess a school child's gross motor skills and to provide teachers with the capacity to implement certain exercises within the classroom or guidance regarding when to refer a child to a physiotherapist. To facilitate resource implementation, staff education sessions were provided by physiotherapy students to ensure teachers were aware of the resource and how they may be used. Also, as most teachers were accountable for the physical education of their classrooms, physiotherapy students provided a suite of exercises and games, such as Tai Chi, for teachers to use to improve gross motor and concentration skills among school children. Both support and school staff felt that the sustainable resource was 'a living document' that has broader

implications for new staff and other local schools. It was suggested to be "one of the most powerful things that could have been done" (School staff).

From the student perspective, three students commented on the positive impact developing the sustainable resource had on their learning and how the placement was more primary health rather than acute focussed. They stated:

> *This is the only placement that I've had that's focussed more on leaving the place with something rather than fixing the patients that are there. (Student, FG3)*

> *I think in this placement we haven't been treating in acute so much as like long term... conditions... So we're trying to influence the[m] long term rather than trying to fix something. (Student, FG3)*

> *I think the placement's unique in that whenever you're running a program in any other placement... you're running someone else's program whereas... we've had to go from nothing to something that could be taught to teachers.... So it's been good experience in getting to develop something like that, you don't often get the opportunity as a student. (Student, FG3)*

Benefits of the service learning model

Benefits to physiotherapy students

The physiotherapy students demonstrated a high level of flexibility and resourcefulness, particularly when plans for the day were disrupted or other pressing matters arose and many staff recognised this among the students. The physiotherapy students also showed initiative to identify deficits among children, while ensuring that simple and achievable outcomes could be performed by the teachers. The resourcefulness of the students to develop interdisciplinary education/practice demonstrated that they were not merely focussed on the 5 week placement and their own assessments, but recognised the potential difference that could be achieved long term.

In addition to the objectives and goals the students had to achieve while on placement, many staff indicated that there were other benefits that were gained by the students, such as autonomy, adaptability, initiative, discipline and problem solving. This was outlined when they said:

> *I think that was one of the benefits that they may not have necessarily seen,... there was nobody telling them they needed to be at school... they had to figure out how*

> *the whole school environment works and for a lot of the time they needed to be independent and actively finding things for themselves to do. (Support staff)*
>
> *The physios also engaged a lot with the staff informally in the staff room, so there was a lot of positive rapport and... picking of each other's brains about certain things and the physios were equally interested in what the teacher could tell them about best ways to manage a child. (School staff)*
>
> *They weren't required to spend time out in the yard in their downtime, but most of the students did that. They would go out and play with the kids at lunchtime or run lunchtime programs or actually engage with them beyond what they were expected to do. (Support staff)*

In addition to their own abilities, the students, as a group, had the opportunity to work with and rely on each other throughout the placement. This was felt to be a positive of the primary school service learning model. It was indicated the placement worked well as it was a group of individuals who could work and collaborate as a team, which made the placement more beneficial. Both students and staff stated

> *Sometimes it's good as well, even if you're assessing a child and there's someone else in the room with you they might pick up on something... We're sort of being each other's supervisor. (Student, FG2)*
>
> *I'd have been lost if I hadn't had 2 other physio students with me. (Student, FG2)*
>
> *I liked the model where 3 physios came into the school because that dynamic of having more than one doing the work together... really maximised the learning for them and the impact for us. (School staff)*

Benefits to the school, teachers and pupils

Although placements were 5 weeks in length, the school pupils were described as enjoying having the physiotherapy students working with them and being in the school as it was "giving [kids] an opportunity that they would never have got beforehand" (School staff). This was specifically related to earlier identification of what were considered 'bad habits' and providing support to "primary school students who probably would not have an opportunity to see a physiotherapist privately" (Support staff).

Many physiotherapy students indicated that through many simple activities, small improvements among the children were already being observed. There was recognition that the children had less acute needs than they had anticipated, yet the needs they did have

would take more than 2 to 3 weeks to resolve. It was recognised that some deficits may take weeks and months for improvement to be observed. However, teachers had several comments on what they had observed already among some pupils. One physiotherapy student reflected:

> *I was talking to one of my teachers that I'm working with, yesterday and she was saying she's pretty happy with the positive impacts of those programs that we've done. (Student, FG2)*

Despite the long term nature of the outcomes that were beginning to be observed within classrooms, support staff stated they received positive feedback from school staff. It was relayed that the placement program had "actually contributed to what they provide for students in their school, but also felt that they provided a great learning opportunity for the physio students" (Support staff). Many schools have limited access to allied health professionals due to cost and this has an impact on student outcomes. The primary school service learning model provided intensive allied health support that was low or no cost to the school and it was "really worthwhile... being able to tap into the expertise of another allied health service" (Support staff).

From the teacher's perspective, having the physiotherapy students at the school reinforced what the teachers were instructing to the school pupils, while providing additional professional development for teachers through one-on-one discussion and professional learning sessions. For example, many staff were confident to identify issues or deficits among their primary school pupils, however the physiotherapy students provided additional information regarding why issues were occurring, what impact it may have and how these issues may be overcome. One school staff member stated:

> *I was confident in labelling those issues and those struggles that child had. It was really good for the physios to come in and give me some feedback as a teacher... yes you're doing the right thing, these are other strategies that you can use... I felt very comfortable approaching them. (School staff)*

> *Those professionals coming in and giving teachers feedback is only going to strengthen our process and be better for the learner. (School staff)*

> *The only negative was that we wanted them more in our rooms every day. (School staff)*

Staff from both schools indicated they would be please to have more students in the future; however it would need to be continued through strong partnerships.

Strategically, physiotherapy students allowed schools to experience how different allied health professional could work with teachers and school children. The professionalism of the physiotherapy students ensured that schools were receptive to working with other disciplines. This would benefit future students from a broad variety disciplines that have the capacity to value add to schools where their placement may occur. This is in addition to meeting the "big picture" objectives among schools who are working towards hubs that are able to provide allied health services to students (School staff). One support staff member, when relaying their experience with another school, stated "now they're saying, well actually allied health broadly has something to offer in areas that we don't normally play in, and we would be happy to engage in that" (Support staff).

Challenges of service learning model

The placement processes and approach

Meeting with the principal early on as part of the placement was indicated to be vital to the student's performance and overall experience. Students felt meeting with the principal at the outset of the first week of their placement would ensure they were more prepared and allow them to be more aware children's needs and the needs of the school. One support staff indicated that delays can occur in meeting university goals and objective and "[students] need to have that sit down with the Principal within the first couple of days" (Support staff). The initial meeting could provide guidance and assistance in knowing where physiotherapy students could focus their skills and more specifically meet the needs of specific primary school children. In addition, ongoing support, regular contact and "weekly meetings" (School staff) with the principal could ensure school objectives, primary school children's needs, and physiotherapy student's needs are being met.

Between the two schools, two different approaches were used with the physiotherapy students. One undertook a laissez-faire approach while the other had more "structure" (School staff), where a timetable was developed for the students. There was a tendency for those students within the structured approach to be ahead of the other student group in what they were aiming to achieve on placement. However, the philosophical tactic of the

less structured approach was to recognise the professional opinion and skills of the final year physiotherapy students and allow them to enhance their practice as professionals in the "real world" (School staff) rather than as students. Further it was stated:

> *We didn't know what we were getting into either. I'm not going to tell a 4th year physio student how to do their job because I don't know. But what I want to know is what they know and how they can implement that to support us... they've got to make a professional decision around what can they actually have done in the time (School staff)*

Although the less structured approach was used, it was also suggested that more structure may be beneficial. Using less structured would be dependent upon the needs of the school, the primary school children and the individual allied health students that were on placement. Further it was suggested that it was vital that principals receive clearer guidance or a foundation of what is expected prior to a student's arrival at the school.

Timeliness of consent forms

One of crucial challenges, that students and support staff felt had delayed the opportunity to work with primary school children, was obtaining written consent from parents to assess and work with the children. At one school, less than 20% of parents had returned consent forms with permission to work with those key children that were identified. However, more than 60% of parents from the other school had returned consent forms that allowed their children to be part of the physiotherapy student program after it being heavily advertised and discussed with parents. It was indicated:

> *There was lots of communication with the families, there was lots of come in sign this form, this is what we're going to do, explanations so they would meet and explain. (School staff)*

This was a source of great frustration and had an impact on physiotherapy students' ability to work with a wide variety of school children. In one case, a physiotherapy student who was waiting for the return of consent forms stated "it was... like the first two weeks, we were a teacher's aide." (Student, FG 2)

In some cases, physiotherapy students felt gaining consent was not part of their role or responsibility and that the schools could have prepared earlier to have consents organised prior to their arrival. However, what many of the students may have overlooked is that

gaining consent was an opportunity to speak with and negotiate with parents, while developing skills that would enhance their practise. One support staff member stated "I was really pleased that the students had to do that [as a learning experience]" (Support staff). It was perceived as a good opportunity for students to speak with those who often did not engage with the school or those parents from a non-English speaking background. It was suggested that many students, as they became professionals, would be using these same negotiation skills including the use of interpreters to meet the needs of clients. A number of key comments included:

> *We've got a lot of impoverished, low SES families, single parent families... [talking with parents] is about building knowledge for our families. (School staff)*
>
> *The multicultural thing, that kind of blew them away, talking on the phone to an Iraqi parent, trying to make sense of just sign the form... and then being able to convey what they were actually doing with this family's kid... So I think that was probably a key learning for them as well at least exposure for them. (Support staff)*
>
> *There was lots of communicating with the parents, identifying needs and creating referral pathways... each student spoke to parents... the parents were all very happy, happy to have their feedback and any referral pathway that they could have. (Support staff).*

Using the approach of gaining consent, students were functioning and using skills that would be used in professional practice and it provided many students with the opportunity to meet with parents and discuss a child's needs. The perspective that gaining consent was not their role may be reflective of the student's previous acute experiences or the acute care view point of what constituted "actual practice" (Student, FG2). This was further highlighted by one student who stated "it's not like a hospital where you just go to a ward and see a patient" (Student, FG2).

When discussing these same issues with the physiotherapy students after the final day of their 5 week placement, gaining consents and speaking with parents was subtly discussed in terms of 'preparation work' to facilitate the delivery of their clinical work. While on placement, there were varying views and practices regarding the consent of children between the schools. Yet, students demonstrated their professionalism by following the *Code of conduct for registered health practitioners* regarding informed consent as outlined

by the Physiotherapy board of Australia (2014). Despite ethical obligations of gaining consent, there was recognition that gaining consent from parents needed to be timelier.

Suggestions were made to overcome the delay in gaining consent, commencing practice and working with children. These included gaining consent early in the school year prior to allied health students commencing. Alternatively, suggestions included providing an 'opt out' consent processes, where all parents are informed at the beginning of the year that allied health students coming into the school within the year and if they did not want their child participating, then they could complete and sign an opt our form for their child. Although timely and more efficient, the opportunity for allied health students to interact with parents may be negated in many ways. The opportunity to discuss a child's needs with parents and would also reduce the professional learning opportunities for allied health students.

Dedicated workspace

In addition to consent, physiotherapy students felt they needed dedicated workspace to improve their use of limited time and to allow for more optimal assessments and treatment regimes. Again this may be reflective of the experiences and expectation of acute care placements where there are dedicated physiotherapy spaces available. Despite this, physiotherapy students were resourceful and creative when needing to undertake assessments and working with various children. One student shared their experience and how they adapted to the situation:

> *We were in a space at the end of the junior building which was their temporary library so we were pretty much between bookshelves that we cordoned off and made it a physio sanctuary. (Student, FG2)*

The physiotherapy students were understating of the situation, as both schools were in the process of refurbishing and renovating the large indoor spaces that may have addressed workspace concerns. However, it was clear that there needed to be greater preparation and negotiation between students and staff concerning the use specific or shared spaces as a teacher was concerned with particular spaces that were being used by the physiotherapy students at the time.

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Supervision and suggested models

School staff suggested that placements needed to be longer and would be more optimal if they also occurred in the first half of the year. There was recognition that a co-coordinator between all parties was a vital element of the placement process and that good supervision was provided by the school nurses. The presence of the school nurses assisted the students to not feel completely alone in practice, however school nurses were unable to directly advise or assess specific physiotherapy skills. It was suggested that there needed to be more involvement from the school nurses early in the placement period, while less support at the end. One nurse suggeste:

> *Early on in the placement [we need to be] probably fairly involved, that was just so the students could find their feet at the school...the last couple of weeks... they probably don't really need us that much (Support staff).*

A great deal of the discussion in the second and final focus groups was around what was considered 'acceptable' clinical contact with supervisors. There was an overall desire or at least a 'pull' to be in the hospital setting, under constant or direct supervision and doing what was considered 'normal' practice. There was a real fear around not being 'practice ready' and that the placement had put many students at a disadvantage. However, students recognised that constant supervision would be counterproductive and "detract from the learning around professionalism and independence without really adding much in terms of learning" (Student, FG3). Nevertheless, students were quite vocal around what type of model would suit their needs or how the primary school placement model would work better. The models that were suggested by students were in most cases based on gaining or honing clinical skills in an acute setting rather than the broad development of professional development skills. A number of the models that were suggested included:

- 5 days a week in the school with 1 hour a day dedicated to administration or direct supervision with a physiotherapist for 5 weeks;
- 5 days a week in the school with 3 hours of supervision with a physiotherapist 2-3 days a week for 5 weeks;
- 3-4 days a week in the school with 1-2 days with direct supervision with a physiotherapist for 5 weeks;

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- 1 week of intensive supervision with a physiotherapist and the remaining 4 weeks in the school;
- The current model that students experienced with 4 days in school and 1 day administration, but for end of 3rd year physiotherapy students rather than final year students: or
- A multidisciplinary placement model, as suggested by support staff.

Despite the current views regarding what was considered limitations to the program or clinical skills of students, it was suggested that as a model it would be sustainable long term, if adequately supported and resourced.

When physiotherapy students were asked if they would undertake a school placement again, most indicated that they would not. Much of the aversion to such a placement was centred on the timeliness of information provided to physiotherapy students prior to placement; the timeliness of consent forms to commence assessment and treatments; the current supervisory model; and the concern regarding the lack of specific physiotherapy skill development in non-acute settings. This was in contrast to what was fed back to schools and support staff, who indicated that the physiotherapy students wanted to stay and that they would recommend the placement to other students if a few changes were made, such as the current supervisory model.

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Discussion and recommendations

Findings highlighted that students felt that acute skill development was not available within the primary school service learning model. However, some students recognised the placement facilitated the development of professional behaviours, reasoning and competence required for future practice (Daly et al., 2013; Overton et al., 2009; Worley et al., 2006). It was indicated that the students may not recognise much of what they had developed while on placement until they were working and interacting with individuals, families and other health professionals in a professional capacity.

This suggests that there may need to be greater clarity among students concerning learning objectives and expectations while on placement. The objectives should be to facilitate deeper learning, learning that moves the student to think and analyse beyond current ways of thinking and see the world in a more inquisitive manner that develops greater autonomy (Hattie, 2015; Ramsden, 2003). Due to the student's focus on the final assessment and its application within a non-traditional setting, students were motivated to meet the needs of the assessment rather examining what could be gained from the experiences they were having within the primary schools. The experiences should allow students to build on prior knowledge, through peer learning, and peer and self assessments that assists a student to self-correct, learn, adapt and negotiate. Although overly simplistic, these complex processes provide better outcomes for student learning (Hattie, 2015; Ramsden, 2003).

As has been highlighted among students, school and support staff, physiotherapy students were able to develop their professional identity and develop professionally through the autonomous learning experience, while being supported through group learning and intra-professional communication and collaboration (Clarke et al., 2014; Lekkas et al., 2007). The students also had the opportunity to experience how the discipline functions within the community setting, which may become fully appreciated and valuable once students commence professional practise or their own private practices. Although there was still the draw towards acute care practise students were beginning to arrive at a new perspective and understanding concerning the profession and the professional self (Clarke et al., 2014, p. 226).

There were benefits for the children as they were able to have access to allied health services which they may not normally have access (Dunbar et al., 2002; Splett & Maras, 2011). It also provided avenues for communication between schools, physiotherapy students and parents regarding a child and how an intervention may ameliorate identified issues. Although many interventions may not have been able to see outcomes within the placement timeframe, a number of children were assessed; parents were informed and engaged within the process. Further, plans and protocols were implemented for teachers to continue once the physiotherapy students had completed their placement (Dunbar et al., 2002; Splett & Maras, 2011). Among those school children where interventions were provided, additional follow up may be required by future students who may have placement within the schools.

An additional benefit of the primary school service learning model may be the exposure among disadvantaged children and parents to various career opportunities in health. It is suggested career choice is developed at primary school (Gorton, 2011; Hartung, Porfeli, & Vondracek, 2005). The opportunity for parents and children to interact with various allied health professionals may create greater awareness regarding the array of health careers that may be available and develop greater interest among children and parents (Hindmarsh, 2003; Knight, Abdallah, Findeisen, Melillo, & Dowling, 2011).

The primary school service learning model provided support to school children and also facilitated greater professional development among the primary school staff through interprofessional exchange, skill development and acquisition of resources (Bakken, 1996; Dryfoos, 2002; Dunbar et al., 2002; Thew et al., 2008). Although there was concern about the teacher's confusion between the roles of an occupational therapist and physiotherapist, the students were able to work with most teachers and also facilitated professional development workshops to address the confusion. As more allied health students are placed within schools, the confusion concerning allied health and the hesitancy concerning allied health students that some teachers experience may be further resolved or reduced.

Overall, there the primary school service learning model implemented was viewed as successful, however there were a number of suggestions made for improvement and many of these are modifiable within the current model. It has been suggested that establishing, planning and monitoring service learning models is time-consuming and costly to those

implementing the placements (Clarke et al., 2014; Lekkas et al., 2007). However, strategic planning, innovative approaches and commitment from key stakeholders may facilitate the viability of such programs into the future.

Recommendations

Based on the key findings within the study, a number of recommendations are offered for consideration:

1. To facilitate greater confidence in primary school placement, students could receive more detailed information prior to arrival concerning the placement, expectation of their role and nature of clinical care they will provide. In addition, to assist greater preference selection of primary school placements, students could be better informed concerning the placement.
2. Learning outcomes, competency assessments, and skills that will be developed while on placement could be more clearly articulated and defined. This will assist with student expectations of a 'non-traditional' placement while helping students appreciate the advantages of the placement.
3. Encourage a preliminary 'meet and greet' between allied health students and teachers/principals to discuss the role of the health profession, highlight school children who teachers have identified, and to initiate interprofessional exchange.
4. Facilitate parental consent at the beginning of the year in addition to ongoing awareness of the allied health program throughout the school community. Alternatively, provide an 'opt out' consent process, where parents are informed of the allied health program and indicate if they do not want their child participating. Regardless of consent process, allied health students need to communicate with parents where a child has been assessed and requires intervention. This will ensure timeliness of program, open communication with parents and assist learning objectives of the allied health student.
5. Recognition that students will need adequate workspace to undertake placement.

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