Video Transcripts for ClinEdAus videos

Video location	Transcript
https://www.clinedaus.org.au/topics-category/student-placements-with-first-peoples-150	'Everybody's business' Dr Alison Nelson - Institute of Urban Indigenous Health I think the first thing that is really important to understand is that people often think if it's a placement in Aboriginal and Torres Strait Islander health it's some special thing that's 'over there'. And, really learning how to be a clinical educator and learning how to be a student working with Aboriginal Torres Strait Islander peoples' is anybody's business. So, for instance, in southeast Queensland we have about 50,000 Aboriginal and Torres Strait Islander people living here. So even if you're working in a big city hospital or a community health centre there's going to be a need for you to know how to work with Aboriginal and Torres Strait Islander people. It's not something that is just a specialist area, it really should be everybody's business and it's something that everybody should be thinking about. The other myth I'd like to debunk is that often people think about working in Aboriginal and Torres Strait Islander health as too hard; it's too complex; it's too difficult and really it's not! The principles that we're going to talk about and those that are identified in this portal are really principles of best practice for working with anybody. There are challenges like there are challenges in any area of clinical work or in any area of clinical education and I think it's really important that we don't put it in the 'too hard' basket or think about it as being too complex because it's actually a really rewarding thing and a really satisfying thing and something that can teach you skills for any area of work that you might be working in.
https://www.clinedaus.org.au/topics-category/benefits-of-student-placements-with-first-peoples-60	'Benefits of clinical education placements within an Indigenous Health context' Jodie Currie – Institute of Urban Indigenous Health – Director of Community Engagement Dr Alison Nelson - Institute of Urban Indigenous Health Students are so inspiring that's the thing - we always get bogged down in the different things that we're doing and it's great for them to come in. They're inspiring because they're new and they're fresh, and they're green, and actually rather than seeing that as a deficit base from 'having a new kid', actually celebrating that as a good thing because they bring other energy then into what it is that you're doing. The opportunity to actually work and engage around relationships with Aboriginal Torres Strait Islander peoples, with non-Indigenous people who work within our sector, and also non-Indigenous people who come in as clients, the

	whole thing around cultural competency, is all just frameworks developed within a white construct. The best way to be able to know and be a part of Aboriginal Torres Strait Islander people's lives is actually working in with them. So, the opportunity for us to actually have the student so that then when they leave us we do know that they have some competency or understanding into the complex inter-relationships that we have with each other and our community and our land and our culture and how we do things is important. In terms of student placements there's huge benefits to our organization - we get extra people power, we get to learn from the creativity that students bring, but there's also some challenges. It often takes a bit more time and creates bit more workload. We recognized that the advantages far outweigh the disadvantages. The learning that we have collectively because of the student input and the benefits to the organization have just been enormous in terms of being catalysts for growth in the workforce across allied health. It has meant that we've been able to demonstrate the need for an occupational therapist or a speech pathologist through a student placement and then been able to recruit to a position that's full-time now in our clinics. So, I think that's been a really exciting aspect - that students have really advocated in a funny way, not intentionally, but they've really been able to demonstrate the need for those extra people to help provide ongoing support to Aboriginal and Torres Strait Islander people and you know at the end of the day that's what it's all about - Trying to improve those outcomes for people and improve access to services for people who wouldn't otherwise be able to access those sorts of things.
https://www.clinedaus.org.au/topics-category/benefits-of-student-placements-with-first-peoples-60	'Indigenous Context Clinical Placement Experience – A student's perspective' Institute for Urban Indigenous Health I'm Sophie, I'm studying occupational therapy at UQ and have been here for about three weeks working with adults with chronic disease and paediatrics on one day. We're also doing the 'Work it out' program providing education. I think meeting a range of really diverse people and understanding their backgrounds and where they have come from has really prompted us to look where we've come from so it's gaining those perspectives. We've done a wide variety of things like chronic disease and I really feel like you are helping people so it's really great.
https://www.clinedaus.org.au/topics-category/developing-cultural-awareness-152	'Understanding Context' Dr Alison Nelson - Institute of Urban Indigenous Health You know one of the principles that we talk a lot about in the placements that we run with Aboriginal and Torres Strait Islander people is that it's really important to be client centred; understand the client's context. There's enormous diversity amongst Aboriginal and Torres Strait Islander peoples so you can't expect that the first person that you meet, and talk with, and work with, as a therapist or as a student is going to have the same context to somebody else.

	There might be some people that you work with, some families that you work with who are from middle-class families and might be similar to my background. But then there are going to be other families that I might work with who come from families that have really struggled with poverty or have other socio-economic difficulties. There are other social determinants of health at play, and I think that the understanding of the social determinants of health is key to working in this area. We need to understand that whole context of somebody's life not just that they're the person sitting in front of us with a broken hip or whatever it is that they come with. They have context, with a family and with a whole bunch of other skills and knowledge, and we need to be able to understand that to get the best outcomes. That's really our job as a therapist, or as a student working in this area - to understand that context and knowing what is going on with that family or with that individual and there's a bunch of different ways that we can do that. I think one of the most important things is developing a relationship with our clients and taking the time to do that. Sometimes it might take a bit longer to develop trust, because of the history that we have had in Australia, particularly with non-indigenous health providers and Aboriginal and Torres Strait Islander people, so it might just take a bit longer to build that relationship. In terms of getting the outcomes that you want - it's really critical that we do that. We often get bombarded with knowledge at university about the sort of statistics around Aboriginal and Torres Strait Islander peoples, so we know that there are poor health care comes, and poor education outcomes, and poor employment outcomes, and we don't mean to, but we can sort of make this subtle shift subconsciously - therefore you know when we hear about an Aboriginal Torres Strait Islander client we think about the deficits, and we think about the problems, and we don't think about the strengths and the resilience. Just like we would with any other client, in occupational therapy, we're taught to see the child or the person with the disability not the disabled person, and it's the same kind of principle - we need to see the client who's in front of us; who comes with strengths and resilience skills, and abilities and knowledge, and it's an opportunity for us to build on those things and to tap into those things rather than thinking that we're coming from this platform of deficit and dysfunction all the time. I think that's probably a key shift that I think our students make when they're on placement with us, students come with this platform of you know all the need and the problems, and yes there are needs and yes there are challenges but there's also a lot of resilience and a lot of things we can learn as students and as practitioners that will then help us to be better at what we do through our interactions with Aboriginal and Torres Strait Islander clients. In terms of understanding that context, there's some practical things we can do. We've talked a bit about building relationships. We can also build really good relationships with Aboriginal and Torres Strait Islander people in the environment around us so if you're lucky enough to be working in an Aboriginal Torres Strait Islander context, then

	there should be a good number of people around that you can draw on their knowledge and expertise. If you're working in a hospital, or a community health centre, it might be that you get to know the liaison officer or it might be that if the client comes in with another family member you build a relationship with that family member as well and that also helps you understand that context and understand what other supports are in place with that person. It's not uncommon for Aboriginal and Torres Strait peoples to have many services involved but none of those services know who else is involved. So it's really important to find out you know what other help is out there for that client what other things are going on and how can we help them navigate the system as well because we all know that the whole system can be a bit tricky to navigate times. That's a really important aspect of what we do as well. Going to things like NAIDOC events, going to community days, also gives you an opportunity to have a look at that client in a completely different context, to understand how Aboriginal and Torres Strait Islander peoples work together, how communities work together. We can then get a better understanding of how all those bits of the puzzle kind of fit together and ask good questions. Not making assumptions and maybe even asking those questions in different ways as well. It might be asking a question and then coming back around to that question a little bit later in asking it in a slightly different way or checking in with the information because sometimes it takes a few goes in order to be able to get that complete picture just as it would with lots of different other clients as well.
https://www.clinedaus.org.au/topics-category/developing-cultural-awareness-152	My Story – A Reflection Tool Samara Dargari and Dr Alison Nelson – Institute for Urban Indigenous Health When I first meet the students, the first question I ask them is: "Where do they come from and what's their family background?", because with our mob our first questions are: "Who are your mob? Where you from?", so then I've put that back on them. Some of them don't know and some of them do know which is great. I'm going to talk a little bit about a tool that we use to help students reflect on themselves because the other thing that we do when we think 'Oh I've got an Aboriginal Torres Strait Islander client or I'm working in an Aboriginal and Torres Strait Islander context is I need to understand those Aboriginal and Torres Strait Islander people'. But we forget that we also need to understand ourselves. We need to understand where we've come from, because that has an impact on our interactions with Aboriginal and Torres Strait Islander clients. We're not so good at that particularly if we're from the white Western cultural background. We're from the dominant culture, it doesn't get questioned, it's the norm in our society, so we don't have lots of opportunities to sort of really think and critique those values. We just take them as a given, that it's the normal way to think, and often it's not until you go overseas or you're embedded in another cultural context that you start to see that actually it's not the way everybody thinks. It's the way that we think and the way that we do things, so one of the tools we use is a tool that we've called 'My Story'.

	What we get the students to do at the beginning of their placement, we do a bit of an orientation process, and then we talk about understanding where they come from, and what's their story. We specifically get the students to think about what's their background, what's their cultural background, what's their educational background, what are their values, what are things that their family has brought them up to think are really important. Reflecting on how this might impact on their work with an Aboriginal and Torres Strait Islander person. The tool is really useful for a few reasons: One, it gets the students starting to think about that and reflect on it for themselves, and they often find that quite challenging. And usually it gives you a really quick indication as a clinical educator of which students are more self-reflective than others. The other thing that it does is provide us with an opportunity to give them some feedback. It helps to highlight maybe some of those hidden assumptions that they're making, that they probably weren't even aware they were making. It's not done as a critique or as a critical sort of thing, it's more done as a way of helping the students start to reflect and then highlight some of the things that might be really key for them to start to question their assumptions and even just to raise awareness that we all make assumptions because we all do! It's just that we're not always aware that we do. So we find that a really useful tool as a reflective kind of tool
https://www.clinedaus.org.au/topics-category/developing-effective-relationships-with-first-151	Building relationships Dr Alison Nelson – Institute for Urban Indigenous Health and Amy Smith (3rd year Occupational Therapy Student) Dr Nelson: You know that aspect of building relationships is important. It just extends what we already know about working with any person - you need to build rapport, it might just take a little bit longer to build that relationship, and to build that trust. I try and be pretty humble in the way that I approach clients if I'm meeting them for the first time. So I'm friendly and I'm warm, but I'm also pretty humble so that I'm letting people know that I'm there to learn. I always say to my students you're in the box seat because you know that you don't know everything, so you're not going to turn up and try and be somebody who knows everything. You're there to learn, and I think that really helps. Often our clients find that they really love having students around because the students take the time to learn from them and they want to be taught by them and they want to learn, and I think our clients respond really well to that because they really can to take that that role as well. I think it needs to be genuinely reciprocal, so it's not just about us as the therapist or us as the student asking questions of the client, it's also about giving some information about ourselves. One of our students gave me some

	feedback and said 'I've never talked about football so much in my life!' - because all his clients would come in the door and have their footy jerseys on. It was a way of connecting that he really liked football, his clients liked football and they could talk about football. Now not everyone's into football, so you know there might be that there are other ways of connecting. Often because I work with children and families, I'll often talk about my own kids. 'My son did this today' or 'My son really likes Skylanders, your son likes Skylanders'…Just those really simple things and they might seem like such little things, but they're great ways of connecting and putting somebody at ease to let them know you're there to help. Given our history of removals of Aboriginal Torres Strait Islander from families when you work with the parents it's such an important thing that we give them a way of connecting with us and we affirm them as parents. We let people know we go out of our way to be extra warm and friendly and to let them know that we're there to help, we're not judging, we're there to provide some support to them. Acknowledging that they want the best for their kids like any parent, and so it's really important that we portray that information in the way that we approach people. We are gentle and humble, we share something about ourselves because that helps break down that sort of power imbalance that sometimes happens when you're working with a client. That's a really important aspect of building the relationship as well. I think the other thing about building a relationship that actually helps us be culturally safe, is that it helps us overcome cultural faux pa that we might make. Students come into a placement in Aboriginal and Torres Strait Islander health, and they have been anxious because they don't want to do the wrong thing and don't want to say the wrong thing and they're not sure if there's rules they should be following, to a make eye contact or don't I, and often those protocols would be different depending on where you are so it's hard to know. In fact it's impossible to know everything that you need to know but if you take that approach of building a relationship with somebody, then if you do make a mistake, people will let you know. That is not always a comfortable feeling, but I think I look at as a positive. I think if people pull me up for something, (and I've been working in this space for a really long time but I still make mistakes), if people pull you up for something, I sort of take it as a positive, that they've taken the time to let me know they haven't just walked off and gone 'Oh she's a bit stupid.' If they've taken the time to let you know, and I think again being humble in that situation, and being able to be learning (being a learner not a teller) It's really important that you've got that sort of teachable aspect to what you're doing, and you'll learn a lot as you go along because of that. But you'll also get forgiven for those little mistakes that you make along the way. I think that's a really great way to approach things. Amy: I think the most important thing is to really take the time to build rapport. I know it's important in every setting, but in this one it's even what I feel like it's even more important, and so it may seem like you're wasting time building that

	rapport but it'll actually benefit you in the long run, because if they trust you, you'll be able to help them, so it's really important
https://www.clinedaus.org.au/topics-category/the-structure-or-nature-of-the-placement-64	Multiple mentoring placement model Dr Alison Nelson – Institute for Urban Indigenous Health One of the other student placement models that we have is a multiple mentoring model. As we've grown and we have more students and more therapists in the mix, we now have student placements that based on a team of supervisors working with a team of students. So, we might have two or three or four students and two or three or four therapists and they share the load. The students might spend a day with one therapist and another day with another therapist and they work as a team to provide that supervision. Now there's a few advantages to that and we've done some research around this, but one of the advantages is that it provides the opportunity for junior therapists who are supervising for possibly the first time to get some support for more experienced people. It gives you a bit more confidence if you've got a struggling student that you know it's not just you and 'Am I just doing a bad job as a supervisor', it gives the opportunity for you to get some affirmation from other people in the team. Some of the supports and the learnings that we have amongst the team around strategies that we can use to support students have been really useful. I think the thing that students get from it, is that they get to see a range of different styles. So they might not naturally click with one of the supervisors, but they might really click with another one so it means that they're not stuck with the person that they don't click with the whole time, but they can also learn from a range of different styles. It can be a bit challenging because sometimes it means the students need to be able to accommodate those different styles or accommodate different ways that the supervisor might approach progress notes or approach report writing. We try and have some uniformity amongst our team, but I think that's also a good skill, because it teaches your students to be flexible, and to think about different writing for different audiences and skills that you might need to learn along the way. As long as students know that this is going to happen, then they are usually okay about going along with it and negotiating and navigating the sort of the differences that might happen between therapists.
https://www.clinedaus.org.au/topics-category/the-structure-or-nature-of-the-placement-64	Multiple students and shared supervision Jodie Booth – Occupational Therapist, Deadly Ears Program

and https://www.clinedaus.org.au/topics-category/placement-models-and-approaches-to-supervision-88	Having more than one student is something that we've managed across services within Queensland Health. Often I've had the opportunity to share students with the child development program, and we've been able to have days where I'll have both the students and then days when they'll have both the students and then days when the students are separated. That works really well for my student to have some experience in child development in its most traditional form, and then for the student at child development to know and understand working with Aboriginal title hundred children and families. And then those students can then work on different projects that can be beneficial for both places together. We've only ever sort of taken up to two students in that model because there's only one of me here, and I also do a lot of outreach. So often when I'm on outreach, I'll make sure that my students spend a little bit more time over at the child development program, but I also have the support of colleagues here, so my team leader and the speech pathologist and anyone else around can ensure that the student feels safe and supported. I'm always on the other end of the phone, and can do supervision over the phone whilst I'm away. Having two supervisors I think it's really important that you know each other well beforehand because if there's any differences in the way that you've practiced in your profession you need to be able to discuss them really openly and honestly so that your student doesn't then have to pick a side. So that the students feel that they can have a trusting and open relationship with both supervisors. So that needs to be able to come from us as supervisors. What we do when we are planning for placements include the logistical planning - so which days will the students be in which places. But we're also in occupational therapy we have the SPEF-R tool as our document for assessing Students. We will specify different aspects of that tool, so that the students will know that different aspects will probably be addressed more in one site or the other site, but there might be specific things that we want them to be doing across both sites. We do that in the lead up to placement, so that when the students start the placement they have that document ready for them to know and understand how they'll be assessed upon, both from the project placement perspective and the more clinical placement perspective. That doesn't that doesn't happen for all assessment items but for the ones that we know that they'll probably not get at one site, but they will definitely get at the other site and vice versa, we make that quite clear. Then at half way through placement, if there's anything that the supervisors haven't had the opportunity to assess, we can make sure that we develop those opportunities for the student in the second half of their placement.
https://www.clinedaus.org.au/topics-category/the-structure-or-nature-of-the-placement-64 and	Shared Clinical Supervision Antoinette Fitzgerald – Occupational Therapist We've over a number of years had some shared placements with the Deadly Ears service. They are another team within our broader organization of Children's Health, but we work at separate locations and have very different roles.

https://www.clinedaus.org.au/topics-category/placement-models-and-approaches-to-supervision-88	What we found is that the Deadly Ears team were looking for clinical experience for the students, and the students that we were having here, were struggling to having a full-time capacity just because of the workforce, and lots of supervisors being part time. So having the option for the students to be part time with both sites is good. It does take a bit of organization in the first instance to plan the placement, and for however many weeks, clearly negotiate how much time the students spend at each place. Making it as equal as possible seems to work better. If they are a little bit more at one service compared with the other, you just don't get them to progress with their learning in their skills and having adequate experiences. So, making it as equal as possible, and pre-booking in supervision times and booking meetings between supervisors so that prior to the point where you have to do the halfway assessment you have had time to have a discussion, and then booking in feedback times with the students in a joint way - if all that's booked in advance then you don't get overwhelmed with the busyness of placement. Another thing that we've done over time is thought a lot about how supervision works in terms of what's required for different placements. Where the student is with us in the child development service is doing a much more the clinical role, you need a different style of supervision compared with when the students are during the project placement. Negotiating that with the student up front, letting them know that there will be differences and how they will engage with one supervisor might be very different to how they engage with another supervisor. We've had to do that up front, so those differences are expected rather than something that they have to work out along the way. So planning it as much as possible with the student beforehand, is what tends to make it work. So it does in a part-time capacity make it much easier to have students, and I guess we've all sense of responsibility to help students as well so it makes that more doable. I also think it gives you a good opportunity to learn from each other if you're sharing a student and you're having to chat along the way in terms of your own student supervision ability, I think that you learn from the other supervisor. Our particular relationship with Deadly Ears allows the students to see quite different models of service delivery and experiencing the OT role in both of those environments and being able to compare and contrast what they are using to get a real perspective of what an OT can do in different in different environments in different contexts
https://www.clinedaus.org.au/topics-category/the-structure-or-nature-of-the-placement-64 and	Community engagement through clinical education placements Antoinette Fitzgerald – Occupational Therapist So as a child development service, our core business is supporting the needs of children who have developmental difficulties. We identify that indigenous children have a higher risk of having developmental issues and so

https://www.clinedaus.org.au/topics-category/placement-models-and-approaches-to-supervision-88	although at a clinical level we don't have the services to provide a specialized indigenous health clinic (that's not what we are funded to do), we have a worked over a number of years that trying to develop our relationships and other links with different indigenous health services, there's an indigenous kindy and play group in their community and we have developed some links with them. So although we can't offer a direct service, we have been trying to develop some relationships to improve access for the indigenous population to our service. The director was a very strong advocate for actually wanting allied health services to come into the kindy and work with their kids, and so we decided to use a student placement model to see whether we could both address that need, and then through that, start to work on that relationship, and also start to capacity build within that kindergarten their ability to identify which children actually have developmental issues and also how they support those parents to access allied health services. We started with some student placements where we had OTs and speech students going to that community in the week. So doing a shared placement model with Deadly Ears meant that the supervision of that was shared. For my time it wasn't as much of a demand. And over the 3 or 4 years where we have done that what the students actually go on and do is quite different now to what it was initially. So what the director wants still is different, but she has started to appreciate I think more what OTs and speech pathologists can add to the program how that can be incorporated as part of the program rather than something different that happens when they come in. The director and the teacher aids who work in that program have definitely changed in a way that they've been able to identify which children are needing more assistance than others. I think that we really have been able to develop a really strong relationship and improve that capacity with that director, being able to strongly advocate for those families to access services and what we do. At least those children can access the support that they need. And then obviously the students in terms of their learning get a whole range of different things - so they're in a kindy environment, and they're seeing the range of normal development down to our children who have some significant delays. They're being asked to apply their skills in a different way, so it's quite a different experience working with a large group of children versus one in a clinic setting. Then in terms of the indigenous health side, they're working with the deadly ears model of community engagement. There's a lot that we ask them to do in terms of engaging with the director, planning out what it is that she needs and wants, and then asking her at the end to evaluate how things have gone, and whether they provided the things she needed them to provide. There's a lot that they are learning specific to an Indigenous population, and there's a whole lot of cultural information that is really important for them to know about and find out about and think about in terms of their practice. They're looking to whether their practices culturally appropriate in terms of what they're asking the children to do as well making some judgments about engaging and how you interact in a culturally sensitive way.

https://www.clinedaus.org.au/topics-category/the-structure-or-nature-of-the-placement-64 and https://www.clinedaus.org.au/topics-category/placement-models-and-approaches-to-supervision-88	Project Placements Dr Alison Nelson – Institute for Urban Indigenous Health At the Institute we have a few different models. We have project placements, and our project placements have been really successful. We have used them across a range of disciplines, but particularly our occupational therapy project placements. We used project placements when we first got going with student placements, and some of our students developed some of the best programs that we now have running within the Institute which is really exciting. We have a chronic disease rehabilitation program called 'Work It Out'. That program began with a couple of occupational therapy students on a project placement pulling it together. We then trialled it with some exercise physiology students, and then evaluated it with some other occupational therapy students who were on a project placement. That evaluation led to us being out of submit to government for funding and that program now runs with a full complement of allied health with extra students involved. So it's a really great example of the success that you can have with project placements - if they're well-structured, well supervised and have a really clear goal of what the outcome is. We have a number of project placements every semester that are involved with things like developing new packages or programs that we'd like to trial. It's a great opportunity for the students to learn, it's also a great opportunity for us to benefit from student's creativity and knowledge. It's a real partnership and I think the way we've tried to establish our student placements is that kind of 'win-win' mentality that students get a well-supported experience, they're well oriented, they get lots of time that they can spend with Aboriginal and Torres Strait Islander people to learn from them, but the organization also gets something out of it so it's not just about students coming along and it's 'all about the student', it's very much a reciprocal kind of relationship where everybody gains.
https://www.clinedaus.org.au/topics-category/the-structure-or-nature-of-the-placement-64	Benefits of project placements Jodie Booth – Occupational Therapist, Deadly Ears The term 'project placement' might also be associated with 'we ran out of supervisors' or 'we didn't have enough placements to give you'. I think that it's probably been tarred with an unfair brush! Project placements aren't the 'dud'. There are so many opportunities that come with a project placement - students need to be reinforced that if this is your project this is how it's linking to a bigger picture. If they can understand that from the beginning then they'll kind of get as passionate as you are about a particular project that they're working on. We have a population health approach, and I suppose with where we are in terms of health funding and all the different changes that are happening state and federally, that we need to think about doing things differently and better, and project placements are one way of ensuring students understand that. It enables them to understand a political climate that they might not have thought about before; enables them to understand how you can

	use strategic influence to not only change things for one individual client but change things for a population or group of people who might be vulnerable or disadvantage for different reasons. I think that there are those aspects that if you can give students the lie of the land in the first instance, that they understand how their project is linking to something that's really important, then they may not be so despondent about the fact that they ended up on a project placement. You also have to set a scene that welcome students and that they are not a burden. One of the things that I always reiterate with the students when they're doing projects, is that you have to check a lot of stuff as you go along, and that was one of the interesting things with my last student - because they're so used to doing assignments and then giving the finished copy to assessors, for project placements you have to set up the time frames so that they check in along the way (as opposed to giving someone the final copy). 'Here's my draft let's talk over this'. I think that that's one of the learnings that we've had this year 'you've done an amazing job there's lots of stuff that we need to change about this but we've left a little bit too late in your placement'. It's not to say that didn't do a great job and they weren't going to pass, but it was kind of like 'Ah, we needed to have checked in in a couple of weeks earlier in order for those changes to be made' before your placement ended. The other thing is when students think that they are making you time poor, 'I'm sorry you don't need to check it now'. As supervisors, we need to reinforce to them is that students are one of the main teachers that we have as clinicians, you know, in terms of reflective practice. Students are one of the most amazing ways to develop. If you can't tell an OT student why you're doing something and can't make them understand it, then perhaps what you're doing isn't occupational therapy… you need to think about what you're doing. Is it best practice if you can't discuss it? Is it the best practice for your clients or the communities or the groups that you're working with?
https://www.clinedaus.org.au/topics-category/the-structure-or-nature-of-the-placement-64	Interprofessional Education in an Indigenous Health Context Dr Alison Nelson, Institute for Urban Indigenous Health Amy Smith, third year Occupational Therapy student Alison Nelson: The other student model that we have which is sometimes combined with either the project placement or the multiple mentoring concept is an interprofessional education approach. A lot of our placements are interprofessional - there might be students working across professions, but there might also be students working with therapists even if they're not working with other students from those professions. We have exercise physiology students, OT students, speech students. They will often do placements together, where they are working with one another. That's one of the benefits that they speak about most loudly when we look at their evaluations - they've really benefited from understanding the way that somebody from that other profession works and what they bring to the table. If you're working with a child who might have speech and language needs

	and they might have some handwriting needs, seeing how those two professions can work together. As much as we can, we try and model that within our team as well, most of our allied health team works very interprofessionally, and I think that's really great for the students to be able to see. You might have an exercise physiologist talking about something to do with you know an OT home visit or an OT might be talking a little bit about exercise. There's respect around our professional boundaries but it's really great for them to see how that's modelled across the team. Amy Smith: It's really good getting to work with other professions. I haven't had the opportunity to work with exercise physiologist before, but I find that's really good - you learn a lot about the body working with them and their perspective, and it really does match well with occupational therapy. In the community setting, and especially in the setting working with in the Aboriginal and Torres Strait Islander people it's really important for it to be a collaborative experience.
https://www.clinedaus.org.au/topics-category/the-structure-or-nature-of-the-placement-64	The 'Work it Out' Program Samara Dargan – Exercise Physiologist, Institute for Urban Indigenous Health My name is Samara Dargan, and I'm a Kalkadoon woman from Cloncurry. The role that I play here at the Institute is as manager for the 'Work It Out' program, which is a chronic disease self-management rehab program for indigenous people. The 'Work It Out' program starts off as a12-week cycle two days per week. On a typical day, you'll start off with an education session that runs for 45 minutes. After the education session, they do an exercise session - so it's an exercise program, tailored to their needs. They complete that for an hour, and then after their exercise session, they have morning tea. So it is a multidisciplinary approach - we do have occupational therapists, we have dietitians, Psychologists, research assistants, transport officers, Aboriginal health workers and exercise physiologists. The students we've had involved in the 'Work It Out' program come from a wide range of bachelor degrees so we've got occupational therapists, we've got public health students, we have pharmacy students, we have dietetic students, and we also have exercise physiology students. How they work together within program depends on what criteria they need to be filled or assessed for their uni. The OT students run through projects that can help the 'Work It Out' program. The exercise physiologist students have to do a required amount of contact time with the clients. All students do participate in the education session. The benefits of having students in the program is they bring fresh ideas - so that's a benefit for the program. Another benefit for the program is the clients get exposed to a whole wide variety of Health Professional students which they usually wouldn't get in just a normal setting. The students benefit as they get that exposure to the Aboriginal and Torres Strait Islander culture and they also get the exposure to the elders in the community, which I think is very important. Those exposures from the 'Work It Out' program help them better understand how to deliver in those cultures and I think being very adaptable to the environment makes you then a better physician when you are in your career.

https://www.clinedaus.org.au/topics-category/benefits-of-clinical-placements-in-aged-care-147	Practice placements in the private aged care setting Megan Saunders, Clinical Educator Q: Megan, in your workplace, what do you find the benefits of participating in the clinical education of students? A: No doubt that having students is a great advantage to our service. They bring with them a wealth of enthusiasm, and up-to-date treatment procedures that have been taught by the universities which is contemporary to our practice. For us, it's a two-way learning experience – for the students and for us. Our educators have a lot of practical and lots and lots of experience, but we both gain major benefits from the two meeting up together. Q: Megan, what have you found to be the key features to run a successful placement? A: Communication is one of the major key features from beginning to end to run a successful placement. We have our clinical educators who we actually divide into a primary and a secondary educator. We communicate with them via guidelines that we have drawn up and have sent to both the educators and the students before their actual placements. Within this are just many aspects of what to expect during the placement. For the educators, there'll be information on the mid and interim assessments, and other relevant things to do with our actual placement within the community service. For the students there will be other things to expect - that they might not have come across in other previous placements, because the community and the aged care settings are going to be so very different from other placements that they've been in. We really don't want it to be a total shock for them, and this is one of the reasons why I will meet up with the clinical educators and the students on the very first day just to go through with them what is going to be expected, so that they feel good about the placement. We want them to be part of the team, and that's another reason why we want to really try to incorporate a good team meeting right at the beginning of the placement. Q: Megan, do you have any tips for other clinical educators either generally or specifically relating to your practice Setting? A: Information is the key and as I said before we do send out quite a lot of information. We meet with the student first thing so that they are fully aware and informed of what they are in for in the next five weeks. We need to start these students very early getting involved some of these students are going to be working within the next few months they're going to be qualified, so early starting with patients is a must. Getting them involved; in with the team so that they feel like they're working within a team. Also important for us, is for the students to really enjoy the experience. A lot of our students come back to us and it's a great marketing strategy for mobile rehab, because we have students who come back to us and work for us later on.
https://www.clinedaus.org.au/topics-category/allied-health-student-placements-in-mental-health-103	Dr. Cathy Kezelman describes the benefits of students participating in Practice Placement in Community Managed Organisations from a consumer's perspective.

	I'm very excited about this era in mental health that we're entering - we're moving away from an illness model to one which is trauma-informed recovery oriented and focused on health and well-being. Pivotal to that is the role of consumers and carers, not just as a voice, but people have a say in the outcomes of issues that affect them. Obviously that's around their lived experience, so this practice placement project is very exciting because what it does is allow students to be placed within services within the community management sector, which are recovery oriented. They engage with consumers and with carers and allow students to understand that a person's lived experience is the way to work with and from that people's own aspirations need to be understood, that they need to be supported towards recovery to their own definition of recovery, not one imposed by clinical services. That's a very unique experience and very exciting to see the potential for this to grow. I'd really like to commend the the scoping report put together by Kay Hughes - it's a wonderful comprehensive guide for the future for a sustainable informed model, that allows future collaborations and information structures so that more students will have the opportunity to engage with this process and really understand that true collaboration with consumers and carers is absolutely critical to the mental health of our community
https://www.clinedaus.org.au/topics-category/allied-health-student-placements-in-mental-health-103	Benefits of a mental health student placement – a student's perspective Jamie Williams Occupational Therapy Student Q: Did you have any concerns or apprehensions prior to your mental health placement? A: I definitely did I think because I haven't even done any units at University in mental health so definitely there's a lot of stigma even just between in general. My friends are still ringing me at the end of the day sometimes and saying you know 'What's it like? Is it really scary? Are the people really crazy' so I was like pretty anxious about coming in. Q: How do you feel now that you've commenced placement? Now I'm into it, I feel like it's been a really easy transition, it hasn't been scary, I don't have any issues that have bothered me. It's just been really eye opening. It's just like everyone is just like the people you would meet on the street and they just happen to have a mental illness and so they can function quite well most of the time, it's just sometimes you know they can't, and they're just here for a bit of extra Help. Q: What are some of the tips from clinical educators that have helped. I would say definitely by having a journal each day. A lot of things go on it's very different to any placement I've done before. I've done a rehab placement and disability services so coming in here everything is different. When you assess client, you have to think about different things.

	I think journaling is really important to keep going that as much as you can, and also being the open with my supervisors, that's really helped. I feel like I could go and talk to them if I had an issue. Taking the time to reflect with my supervisor is really helpful - I think sometimes it gets really busy you don't have much time, so as long as they kind of drop that into their schedule as well then I know I actually have the time to take away and reflect on things.
https://www.clinedaus.org.au/topics-category/allied-health-student-placements-in-mental-health-103	The opportunities for students who undertake a mental health student placement Wendy Szatkowski – Occupational Therapist I suppose going back to one of my experiences that I had, I was actually in my last year at uni I had a gentleman that had schizophrenia and that had attempted suicide and had quite a serious hand injury. I still remember back to when my supervisor had said 'Oh, he has schizophrenia, we might just leave that one'. And I think at the time I just went 'Oh, ok'. I look back at that now, having worked in mental health for some time and wonder where he is, and about that lack of care that came from something stigmatized by his illness. I think even for people who are not passionate about mental health, it might not be their first preference to go into, they might never choose to work in that industry, I think it's still good to have that background knowledge of where these people are in their lives, how they have this illness, and how it impacts them - not just from a mental health perspective but also in their other physical health care that they might be receiving. Secondly I suppose I did have a mental health placement that I didn't enjoy very much - I didn't feel that I got the same support from the supervisor that I would have liked. I struggled through the placement and towards the end of my group degree, I didn't feel like doing mental health anymore, I wasn't passionate about occupational therapy. I was lucky to fall back into the profession, and so I suppose this is where my passion for educating students comes from. I think that's really important to give them a positive experience and as I said, if it's not what they go into that's okay, but they've got that that little bit of knowledge by that holistic care.
https://www.clinedaus.org.au/topics-category/allied-health-student-placements-in-mental-health-103	The benefits of taking student placements in the mental health setting Wendy Szatkowski – Occupational Therapist In terms of evidence-based practice I think sometimes with our workload we can get caught up in trying to see patients, we don't necessarily have the time to doing literature review to know what is up to date practice, what is evidence-based practice is. Students are coming from the perspective - that's what they're doing up at uni, they're learning about what's happening now, what's the best research, what does this research say. It is useful feedback to us as clinicians as it gives us a better chance to investigate that we are actually up to date with our clinical practice. So utilizing their skills to further our own practice.

	So students have chosen occupational therapy to go into, so they've got some understanding what it's all about, but the majority of the time, when they are at uni, they are hitting their books, they're studying quite hard. They get excited when they come to placement, and that's what we really enjoy, within confidential boundaries, that they can then go out and tell their friends about their experiences, what they're able to do, so they've got that positive spin that can be quite good at promoting OT. I find that students quite often come with loads of questions - they want to know why I was using a particular assessment tool, why we're engaging clients in a specific way, why we would do a home visit or a clinical assessment. I think it helps us quite often as we developed our clinical practice we become automated in the way that we engage with our clients and the way we go about things. I think those questions from students quite often make us actually slow down and stop and think 'Is this an appropriate tool that I should be using?', bringing back the point before about evidence-based practice. Students might have knowledge of new tools have been developed which we didn't know about. It can be good in that regard as it does help you to question everything that you do in your practice. The students will graduate in the near future and I think it can be really important time for making networks and making contacts for the future. I've had students that have graduated and are now working in a separate part of the hospital. It can be quite handy that they've got contacts on the physical side with online care mental health side so if I need a little bit of help with someone okay click them a quick email or get their feedback on what's up to date in terms of practice.
https://www.clinedaus.org.au/topics-category/allied-health-student-placements-in-mental-health-103	Prof Lindy McAllister, Work Integrated Learning, University of Sydney, Faculty of Health Sciences It's been a real pleasure for my faculty to be involved in this project for a number of reasons. One is that it is at the community management sector and it is a sector that's growing. There's a growing demand for services and it is working in different models of care to what our students have typically been able to be exposed to which is more the acute illness. The recovery models and the consumer participation and the collaborative care models are really important for us to expose our students to. So this is a wonderful opportunity for us to be involved. It also gives us the opportunity to involve more students - perhaps that have not typically been involved in these services. I see great potential for example exercise physiology students to be involved, and other allied health professionals beyond those that have traditionally been part of the mental health team. The really exciting part about this project is that people are coming from this with a very fresh set of eyes and so the potential that exists for really high quality learning programs isn't being constrained by very fossilized traditional ways of thinking about how student placements should work. It's been conceived right from the start as an interprofessional learning opportunity for students and really that's where workforce training needs go. Students have to be able to work in teams, they have to be able to work collaboratively with consumers and carers, and all the other staff who are involved. So this is just a fantastic project for our students to be involved with.

	In the future, I think the learning outcomes will be unique and far greater than we're currently getting from many of our other placement sites
https://www.clinedaus.org.au/topics-category/tackling-the-challenges-of-student-placements-in-104	Keys to a successful mental health placement Wendy Szatkowski – Occupational Therapist I always try to start with a warm friendly approach to my student. I'm making sure that I'm getting back to them within reasonable time limits from when they make that first point of contact. I think it's really important to be able to establish that you want them there at the placement. I remember being a student and being really excited to start, and the last thing you want is to have a week in between your supervisor calling back if you know if they've been at work. Giving them lots of reassurance that you know mental health it's an exciting place to come work and then it can be really interesting, but also providing any sort of reassurance if the student does feel be anxious about the placement - certainly there is a little stigma that can be associated with mental health and so trying to knock that on the head right from the beginning and make sure that they're pretty relaxed about coming here. Also just setting expectations for the student from the beginning. Ensuring that they know that that first week of placement also is going to be around observation, that there's no expectations of them other than to just comply with basic clinical or professional boundaries so making sure that they are staying with the clinician at all times and you know asking feedback the feedback as it's appropriate. I find that repeating information can also be quite helpful so often the students coming and trying to learn a lot of a lot of things at once it's not just about what the OT role is, but it's what the other people in a team of doing. It's also what the clients are experiencing, it's the whole hospital system or the healthcare system, so repeating that information I think is quite important for them getting a grasp on what their what they're singing taking note of the individuals learning styles I think it's important to work out the individual's learning style from the beginning - whether they find things easier by writing them down, by having discussions about what's going on, or by actually involving them directly in the intervention. If you find that the student is learning best by perhaps recording things down then journaling might be a way for them to take the time out to absorb what's going on in the environment, what they're seeing, what's happening. However some students might learn by being more hands on, getting them right in there. I think supervision is really important again going right from the start so ensuring that you have a time that set aside for supervision. My advice would be not to let something else get in the way, or get put off for a week, because you find that you get behind and then issues arise where student may not get that time to reflect on what's going on, or by the time you have the supervision session, you have forgotten about

	it or the issue has escalated. It's really important to put that into place as soon as you can ensuring that the students getting those needs met. One of my other tips would be trying to use clients that are willing to participate, as this eases the students into their interviewing skills or their engagement of the clients especially in mental health. I think we don't want to scare students off too early, by making sure that they get a good experience on their first time around and they can build their confidence. Next time they can develop on that. Journaling I find, is a really effective tool for the students. As clinicians, we're spending a lot of time having to document things or follow up on phone calls that the student might not be primarily involved in. I think it's a really good opportunity to take those bits of time and allow the students to do some journaling. Basically where they sit down they reflect on what their experiences have been for the day, how they felt at those times, and it can help them with clinical reasoning skills. Being able to sit back and think 'why did I do this?' or 'how did I feel when I did this?' and then have a read of them before they go into their supervision sessions. This can help to bring back some issues they are burning to discuss in the supervision
https://www.clinedaus.org.au/topics-category/mental-health-settings-practical-support-for-the-106	Mental Health Placement Safety Considerations Hazel Bassett – Homeless Health Team Leader Q: Working with the homeless client group, there are some perceived potential risks and challenges for students. What are some key considerations for clinical educators to work with students, when it comes to working with challenging behaviours? A: My first consideration with students is around helping them to understand that basically this client group not to be considered just as having risks. I guess it's really important for them to understand that this client group have issues in their life, it may cause challenging behaviours, but don't expect challenging behaviours. It's really important that they go in expecting to meet person first and foremost, and not to expect that the person is going to have any sort of challenging behaviour. However you do need to skill them up to know how to handle those behaviours when they actually do appear. It's really important to get them to see people as people first and then to consider the behaviours. And if you can do that then you can actually handle most of the behaviours that will come, and do it in a therapeutic way, and in a way that can actually build rapport. Q: What needs to be considered with students when carrying out a risk assessment A: It's really important that they understand the different components of the risk assessment and for someone working within the team like ours, we not only look at things like suicide risk, and risk of self-harm, or risk of aggression towards others, but we also consider things like vulnerability, and we consider things like what is in the environment, because it's really important when people are going out, particularly and seeing people in other places,

	other than in a clinic setting, it's really important for people to be considering the environmental risks that are out there and they often forget about those. So that's like you know do they have a big dog? Who else is there? Do you know who else is visiting in the home? Who else might be in that general area? What kind of weapons could be there? And weapons don't have to be knives and guns, they can be cups of hot water, or a whole range of things. It's getting students to think outside of the square. Then it's also around other things, so being aware of how to ask questions around you know have you ever felt like life's not worth living rather than saying are you suicidal. Other ways of asking you know have you ever harmed yourself and felt better after that or have you have you ever considered doing something to yourself and was that an attempt to actually die or was more just about letting the anger out in dealing with it. Getting a picture and understanding what the terms are so that you can ask it in different ways. It's really important for students to learn how to do that and to know when to ask direct questions and when to be more broad and let people guide you guide you into telling you about those kinds of things Q: What are your priorities to maintain student safety when dealing with challenging clients? I think it's really important that you have clear boundaries and guidelines around how different procedures happen. Whether that if that's an interview in a clinic, how that occurs; if it's an interview at a bedside, how that occurs; if it's an interview out in the community, if it's in a park for our sake, or at another doctor surgery, or wherever, that you talk to the student about the things that they need to consider as they're going out. Then there's the really practical thing, so putting names on whiteboards and telling people where you're going, leaving contact numbers, having a word that you can say on a phone or a procedure to follow so that if something happens and they need to let you know that there's a problem but they can't actually get on the phone and say I have a problem, talking the students through all of those example. Making sure they're really clear about those but again not doing it so that you have a student who's really hyper vigilant and scared out of their wit's but having a student who can respond when they need to. Again it's really important to given them the message that this is 'in case', and it rarely happens, so it's about preparing students to think through those and I guess it's also about getting the student to think about safety. If you're going into a room where should you be in the room; if you're going beside a bed how close do you get; and if you're seeing someone with a walking stick have you thought about how close you get. Often people don't think about this. You talk about personal space, you talk about not touching things that belong to others. Someone can become really antsy that you've touched their things. So it's all of those kind of considerations. Just in your general chitchat with the student, making the student aware so that they are thinking and even though they will go with someone, it's around preparing them and getting them to think through what could be the risks in this situation, and as you do that, and get it verbalized in the student, it actually helps the student at time they go in, so that's a really good strategy in helping students to consider and manage risk and giving them a very clear

	message about if you feel unsafe exit you don't have to be a hero this is not hero worship time this is about staying safe so exit when you need to.
https://www.clinedaus.org.au/topics-category/allied-health-student-placements-in-rural-and-163	Top tips for a rural and remote student placement Sarah Jackson – Physiotherapist My top tips for somebody working in a rural and right area who is thinking about taking on students I think is 'Go for It'! It's one of the best things you'll ever do, will definitely improve your practice as a clinician, and students get a varied experience. Patients in the area likewise they love contributing to a student's education, they find it's very fulfilling for them as well. I think it's really important that you're linking with other services, whether it's to give you the breathing space to develop the students understanding of rural and remote allied health, anything like that, and where possible get students to link in with each other. Students who come here are pretty lucky in that they share accommodation and we tend to return to separate each discipline and each uni so you know you might have a JCU OT student in with a UQ physio student who is also sharing with the a speech student from South Australia. You might have quite a big variety in that so I think that's a really important thing for students.
https://www.clinedaus.org.au/topics-category/student-placement-models-in-rural-and-remote-165 and https://www.clinedaus.org.au/topics-category/placement-models-and-approaches-to-supervision-88	Clinical education models in a rural and remote setting Sarah Jackson – Physiotherapist At Northwest community rehab, we generally take students in pairs of fours, so it might be two physios and two OT students might be four physio students well . If there's other students in the area, so for example speech therapy, and we've got a participant who we've identified a speech referral as appropriate, we'll try to bring those students in on a sessional basis particularly to this model of community rehab There's definite advantages I find to taking multiple students at any one time. It gives the students a really good chance to develop teamwork skills and I find this translates into their employability later on. If you're getting students from different universities that can be quite beneficial too. They bring different exposure, different experiences, different ideas to the table, so when students are having those group discussions it can make for a really good learning activity and build that into professional learning as well, particularly if you're teaching across the disciplines. Disadvantages, well some might say that there's extra paperwork associated with having extra students, and that's probably true. However I find as a clinical educator having multiple students means that the students can

	bounce off each other and some of those discussions that you would normally need to facilitate as educator to student, the actual two students might work out peer to peer, so I think in some ways that actually saves the clinical educator a bit of time. We've done shared placements over the previous years, so for example we had physio students who were placed both with Mt Isa hospital and one of the private practices in the area. The students found this to be quite a good experience it gave them the opportunity to see two very different sides of rural and remote practice. Logistically, the clinical educators had a bit of a bit of a challenge in finding times for them to catch up and see where the students were at, but we do find that where it's possible, we try to link students in, so if they come with one service for their placement we do try to link them in with other services to develop that understanding of what goes on in rural and remote allied health.
https://www.clinedaus.org.au/topics-category/student-placement-models-in-rural-and-remote-165 and https://www.clinedaus.org.au/topics-category/placement-models-and-approaches-to-supervision-88	An innovated placement structure for a rural community Professor Barbara Dodd I'm a speech and language pathologist who retired about a year ago and I lived in a small country town in New South Wales and one of the things I wanted to do was to run a clinic which was primarily staffed by students that would provide intensive therapy for people who lived in the town. I see our role as being one of being able to provide a service for the community that otherwise they wouldn't get. I take students from Melbourne University for a month, and there are eight of them. They come and they stay in the town in the hospital accommodation or in a house, and that's funded primarily by the University. The university actually selects students who are not only keen to come, but who they also judge to being capable of making the most of a placement. Before students come, I go and visit various places in town to set up the student placements. Last year we had sites in the nursing home, in two primary schools, in one high school, and in a child care centre. I negotiate that each of those places would take two students, and students would be there full time. I also go to Melbourne to talk to the students, where I explain to them that what will happen is that they will be allocated to site which they can negotiate with their clinical director, and they will be given a list of possible clients that they will have to manage. Every student will be observed every day in the first two weeks of the placement and for longer periods every second day for the last two weeks. Once a week the students meet with me to discuss issues, they can also make an appointment at any time, they have also Skype their teachers in Melbourne if they need to.

	Even though I'm not there (because I'm moving around from one clinic to another) there is always somebody on site that they can go to if there's any problem because there's always teachers or nurses or physical teachers who are available for any problem. Students have a fairly interesting time if they're willing to take the initiative and to make the most of the opportunity of that's offered because they can work independently, they work in pairs, so that they get some support. They have a lot of tutorials support. They find that they learn a great deal about what it's like to be working therapists. In that type of clinical placement there have been some students who haven't been particularly strong in terms of their skills but nevertheless they have been very willing to learn and I think that even through hard work that they can still work out to be very successful in the placement. The difficulty would rise if you had a student who wasn't prepared to put in the hard work, who wasn't prepared to be guided by the clinical supervisor, who lacked clinical initiative to actually take on the management role that they have that would be very difficult. The disadvantages are that some students find it quite difficult to make the most of the opportunity - they find being in the town for a month which is fairly small rather challenging. They might not be used to sharing accommodation. The community actually has been very good in the sense that what they do is they put on a dinner. They actually set up meetings with other students who are on clinical placement from allied health and nursing staff and so that gives them sort of social base outside the actual group of students that they are with. They often have some cars between them so they can get away for the weekend if they need to. They do work very hard and then they complain about the fact that they have to work as hard as they do but nevertheless most of them are very positive in terms of the amount over placement.
https://www.clinedaus.org.au/topics-category/managing-clinical-placements-with-outreach-166	Students on outreach visits Jodie Booth – Occupational Therapist Within our team, to take students on outreach happens in different ways. So, our audiologists have been able to set up some student placements for going to our more rural communities or towns. In those cases, the students have had to pay their own way, so if they can get funding internally from the university or through other sources that supports them to participate in that sort of outreach activity, but because that's a quite defined clinical role, that's very different to a speech pathologist and occupational therapists and how our team work. So for us to be able to take speech pathology and occupational therapy students into our work, it doesn't just sit in the health centre, we get many different services organizations and parts of the community we need to make sure that first and foremost we have a really good relationship with the community and if we are taking a student

	with us that that's gone through a consultation process with the key people in the community so from council and the local health centre, any other places and spaces that the student will be with us in that time. I suppose our preference is to the have the students on a fairly short visit. So lots of our business with community would be over three or four days and we probably prefer it if a student attends some shorter visits, because sometimes it can be quite overwhelming, they might not have been in that in that context before. We want to make sure that they feel safe and supported. Also being together for multiple days with your supervisor might challenge that student supervisor relationship a little bit. We need to make sure that professional delineation is maintained as well. Some of the things that we've done to overcome the logistical barriers we can make sure that there's two beds in the motel room so that student doesn't have to pay for additional accommodation. We tend to take students to communities where it's quite a short travel distance so that there are no flights involved and that they can jump in an extra seat in the car. There's only a handful of communities that we visit from OT & speech perspectives that we can actually do that with. I suppose that what's really important particularly in going to remote Aboriginal communities is that the communities don't see students as coming and sticky beaking. That the students are there to learn and understand from the community and that we will make sure that they would meet with community members to hear their perspective and to understand their context from the community's perspective and that's really hard to do when you're up there too to do your job as well so we've got a long take all that into account. The benefit for us in taking students is that because we're more of a population health model we don't see individual clients, so that sort of diminishes risk a little bit, but we're still very protective of the communities we visit so we need to make sure that if for example we had a student who we thought might not be practicing in a really culturally safe way, we might make a decision within the team to state that the student isn't ready to visit the communities because we don't want to risk our relationship with the community just for the student to have 24 hours of that experience. The advantages for students to deliver the communities that we work in partnership with, just to know and understand way of life in remote communities, to really get a feel for the geographical isolation, and for the services or sometimes lack of services that people have, even from a visit to the local shop and seeing how expensive it is to live in that community, or a visit to the local health centre to see that the optometrist isn't coming for another two months or all those sorts of things. Until they're in your face, you just don't understand the isolation of some of the communities and also from a cultural perspective, just being able to meet local people, hear their stories, which you know as a student I think that that's the stuff that I would have liked to know before I graduated.
https://www.clinedaus.org.au/topics-category/managing-clinical-placements-with-outreach-166	Supervision options while you are away on outreach visits Jodie Booth – Occupational Therapist

	My outreach schedule can't stop when we have students. so the cross-site of situation works really well, so that there will be someone in the Brisbane vicinity that can support my student if there are any major challenges. Our team has a really strong philosophy around students supervision and being able to support students even if they're not in under your particular profession, and that comes from our from our director and from a team leader as well. If I'm going on outreach, there other people in the team who will know what the students up to, will sort of just check in on them from you know from day to day, and make sure that they are still feeling like they're part of the team, even though the key supervisors not in town. I will make sure that we set up times for supervision over the phone and they know that they can call me and I'll get back to them. I am available and might not be available immediately but it's okay to call, it's not an inconvenience because you are my responsibility and I need to make sure that you have everything you need to be able to continue your project whilst I'm away. I've had some interesting conversations in car parks of health centres and managed when the reception is dropping out, but workable! Just making sure that I know where they're up to with their project, that they have some deadlines set for themselves, and those sorts of things so that they don't get in a bit of a slump while I'm way.
https://www.clinedaus.org.au/topics-category/preparing-the-student-for-a-rural-and-remote-66	Clinical Education in Mt Isa Sarah Jackson – Physiotherapist I work at the Mt Isa Centre for Rural Health which is one of the university departments of rural health around Australia. I am situated within James Cook University. I'm a physiotherapist originally and I work as a project manager for northwest community rehab which is a student assistant service here in Mt Isa. Orientation plays a really big part of a student placement. Day one students have orientation to MICCR itself and that can include things like practical occupational health and safety information, about their accommodation, what the rules are, it also includes information about Mt Isa itself. In addition, students are invited to cultural awareness day, as well as a visit to outback Mt Isa to understand the history of Mt Isa and how it's developed. Then there's also the orientation to the service - so for students coming on a placement with us they have orientation on the paperwork that's involved because it is quite a big part, but also the model that we run, so not just how the students interact with each other and your supervisor but also the types of programs that we deliver here as part of the service. So orientation is quite a big part to a student placement.

https://www.clinedaus.org.au/topics-category/confidentiality-and-professional-boundaries-on-a-170	Maintaining the work life balance in a rural and remote setting Sarah Jackson – Physiotherapist In terms of work-life balance, I think it's really important that students be connected in with other services. I think this allows supervisor a bit of time, bit of breathing space just to do the other things that they need to do, cross off their to-do list, knowing that the students are also getting available learning experiences by being with that other service. If you're the only clinical educator in the area I would suggest setting up some kind of independent learning activities for the student, whether it be researched based or consolidating your understanding of rural and remote allied health, anything like that. Outside of work I think it's really important that you as a clinical educator have some commitments in the evening even if it's once a week, just something that you go to switch off so you're not thinking about the service or the students all day. I think as clinicians, we do tend to be very self-reflective and so you can spend a lot of your time thinking about how you can make things better which is really great quality, but sometimes you just need to be able to walk away from it as well. So whether it's that you've got your pottery class in the evening, just something that takes your mind off everything that that's happened during the day
https://www.clinedaus.org.au/topics-category/what-is-interprofessional-education-148	Interprofessional education within a multidisciplinary team Antoinette Fitzgerald – Occupational Therapist In our work environment, working the child development program, we work in multidisciplinary teams. A lot of our work is both multidisciplinary in that you are doing things with other disciplines, but there's also a large component of our work that we would say this transdisciplinary - that there's a core set of generic skills that you need when you're working with children and families and that's around some counselling skills, how you communicate with people, how you give general information and advice or a child development child development disabilities and all those sorts of things. That whole set of skills comes through experience and it comes often through working with professionals and hearing them talk to families and learning from them. Because we have such a great environment in terms of having a whole set of different disciplines in one place, what we've done over the years is plan at the beginning of the year, when different disciplines will take students – so look at when there are speech or physio placements and actively trying to schedule them at the same time so that while students are here on placement they have opportunity to learn from their peers, as well as opportunity within the placement to observe other disciplines and learn about multidisciplinary placement. Sometimes we create a little student team so when we are working with the child and family that there are multiple disciplines involved in, the students can get involved in that as well, and so then they can have their own discussions they've all seemed the same child from their discipline perspective and gives them opportunity to try and pull that information together and learn from each other about the disciplines roles, but also how we overlap.

	What we don't do is probably the professional supervision part of it. Each student who comes has a discipline specific supervisor. In an ad hoc way, we would if asked if two students came and watched you in a clinical setting you would sit down and talk to those students and debrief and discuss and discuss their observations afterwards so we do a lot of that where they're getting they're getting that experience during their placement of having opportunity to discuss with different disciplines what they're seeing and observed to clinicians do things in a particular way. Then the other part of that through the exposure to your other disciplines in the team, the students are more comfortable when it comes to case conferences and team meetings in being able to assume the role of the OT in that setting, and present information and discuss a child, to set up the relationships and they start to see where they fit in the picture. If you're more comfortable with the value of your information, you bring more your perspective about a child or family then you are more confident to present that information
https://www.clinedaus.org.au/topics-category/what-is-interprofessional-education-148	Interprofessional education Dr Alison Nelson - Institute of Urban Indigenous Health Duplicate of transcript: https://www.clinedaus.org.au/topics-category/the-structure-or-nature-of-the-placement-64
https://www.clinedaus.org.au/topics-category/a-guide-and-resources-for-interprofessional-135	Supervising students across professions Jacqui Broadbridge – Occupational Therapist Q: Could outline for us how you've gone about supervision for students outside of your own profession of occupational therapy? A: My orientation to these students is generally the same whether they are from my discipline or not because Adult Learning principles apply so it's a consistent methodology. In the first instance, it's always around orientation and the context to the city, and then it's around what they're learning styles are, it's around understanding what their goals are to achieve for that particular placement, it's understanding how they best take feedback, understanding how they're going to learn, and it's about reviewing their goals and also their best method for reflection. I spend some time really talking about their clinical reasoning styles so I think they're some of the big outcomes for that orientation so that generally is my approach. Q: Could you tell us a little bit about what you see is the key strengths and benefits of this approach of supervising students outside of your own profession? A: I think it's probably the way of the future. I think in a lot of the recent research there's a lot of evidence to suggest that interprofessional learning is certainly the way we need to head down in relation to workforce shortages but also in the context that people are going to go out and spend a lifelong career learning from each other and learning from their colleagues who will be other health and related disciplines. So to have those experiences in an undergraduate setting I think is a superb start to a lifelong career

	Q: What do you see as the key challenges in this approach of supervising students outside of your own profession, and how have you dealt with such challenges? A: So one of the greatest challenges that I found is if there is an identity of that profession. So if somebody is supervised by a different discipline it can challenge their own identity and that is developing as an undergraduate. So it is important to allow plenty of opportunity for those sorts of conversations around the differences and some of the similarities between my discipline and their discipline, but some of the unique contributions that they might be able to offer from their discipline. That tends to assist those challenges, but certainly good support from universities and clinical supervision from the universities is always helpful in those instances to finish off with. Q: Could you think of a particularly challenging scenario in this model and tell us how you've dealt with that challenge to successfully resolve the issue? So it's been in relation to that understanding of the personal professional frame of reference and how that might relate to the service context because of course I wasn't the same professional and as I outlined in the challenge previously, the university can offer a lot of support. We can find a lot of shared skills so a lot of competencies and skill sets that are in common then are then really well represented within my practice area so that provided enough grounding for the student to then improve their confidence in how their profession would contribute in that setting and also in what they can gain from their experiences whilst on that placement. So communication and allowing an opportunity to reflect on were the ways to move forward
https://www.clinedaus.org.au/topics-category/characteristics-of-effective-clinical-educators-190	Student perspectives on effective clinical education Rachel Hull and Jodie Connelly – Speech Pathology Students Question: From your clinical experience what have you found really useful that a clinical educator has done? Rachel: Certainly the clinical educators that I've had in the past have provided lots of really specific feedback which has been really helpful. Things like using a certain tone of voice with children; things like not giving too many instructions and repetitions when doing assessments of children's abilities; also providing some written feedback so that I've got something to reflect back on later after I've left the clinic for that particular day. Jodie: I'd agree with that - I find that my most recent clinical educator has given me very specific feedback from that session, giving the examples of what I did well, or little tips as to what I could improve on. I also found it handy that one of my clinical educators gave me very specific information about her expectations and requirements of me from early on: that notes are to be uploaded by a certain day; a two-week turnaround time for assessment reports. I think as well my currency has unbeknownst to me found the right time to tell me when to push myself and increase expectations and requirements of me, so that was really good as well to give me that bit of extra push that I needed Question: Can you identify anything that has made a clinical placement difficult?

	Rachel: My first clinical placement was a little more challenging because we had a lot of children who were bilingual and therefore we weren't able to assess them and to provide intervention in terms of speech pathology. That was that was a bit of an obstacle, and then another that has been correspondent across both of my clinical education experiences, has been I guess the lack of support from the staff that are employed in that particular setting so I found that that has been challenging in both of my experiences. Jodie: There are a couple of things that spring to mind. The first is the first semester placement I found a little bit difficult given the number of students, I think there was six per clinical educator, I found that a little bit tricky in terms of having time to observe other people as well as time with the clinical educator. I also found more recently at both placements the different personalities some people required a lot more time and guidance from a clinical educator than others, and I think that made it difficult for some students to get guidance when they most need it, and I think the most recent experience I'm having a bit of trouble with is… I have a lot of sessions really early in the morning and there are students immediately after me, so I often don't get feedback from my clinical educator and I find that a really valuable learning tool. So making some specific time to catch up with the student to give that feedback I think would be really useful tool. Question: Rachel can you add anything or can you think of something a clinical educator could have done that would have made the situation different? Rachel: I think if a clinical educator can support us to involve the staff in greater level, so (while) I think the onus is certainly on the students to maybe do some in-services of the staff in the workplace, it's good to have guidance from a clinical educator as well. I think some of those strategies to provide feedback as Jodi mentioned, but also things like setting up a Dropbox, or some kind of organized system where everyone can access the same resources. Then it's there for whenever you have the time, and the clinical educator has the time to be able to jump in and modify session plans and give you feedback for example I think even as well having the clinical educator highlight their expectations and requirements really early on in the semester. I have two clinical educators at the moment, and one has been very specific about when turnaround times need to be and I think that that really helps me in terms of organization - knowing where I meant to be going and what's required of me and that is that it's essentially my session - I'm the one there to organize the session plan with support, not the other way around relying on the clinical educator, so just getting that expectations of me and what's required of me really early on
https://www.clinedaus.org.au/topics-category/key-considerations-for-effective-communication-180 and	Smooth running of a clinical placement – tips from a clinical educator Julie Gauchwin Question: Can you please describe your role as a clinical education coordinator?

https://www.clinedaus.org.au/topics-category/as-the-clinical-placement-commences-27	Answer: I work at the Princess Alexandra Hospital in Brisbane which is a very large acute hospital. I helped coordinate the physiotherapy student placements, and just to give you an idea of the volume of student placements last year we've had over 180 physiotherapy student placements. My role is basically to support the placements, to make sure that the placements run smoothly. So I support the educator, help them out if they're in difficulty. If they're having challenging students I can go and give them a bit of advice. If the educator is having a big group of students and is struggling with time I can go and support them whatever they need. Basically to make the role or their role easier. I also support the students. Because I'm not involved in their assessment, I can sort of be treated sort of like an outsider to them and support them during their placement. I've become a link to the University and also I basically support everything that needs to happen to make the placements run as smoothly as possible. Question: With that number of students going through, you must have seen and helped facilitate a lot of difficult situations. Would you please tell us one of the main reasons that difficulties arise in the clinical placement? Answer: There can be few, but often we find there's often some sort of external factor happening. It might be something in their personal life, whether it be financial, family tragedy, stressful situation, or it could be a medical issue. But some sort of external factor is happening, which is affecting their performance and it often can manifest as a student not coping, or the student struggling to pass the unit. Other things is..if communication isn't working - if effective communication isn't happening between the educator and the student, that's when there can be a problem. I suppose it's planning - if the placement hasn't been planned effectively, then sometimes we find that we can have a problem at the placement. Question: Julie not all workplaces are fortunate to have a clinical education support coordinator. What strategies can you suggest that a clinical educator who interacts directly with the student, could use to help facilitate some difficult situations? Answer: I think one of the most important things is to identify the problem early and address it as early as possible. The longer you leave it, the harder it is, and then of course the other thing like with most things, is having effective or good communication - if you can't communicate well with a student I don't think you'll get very far. So there I think they're the most important things - to get it get on to it early and really talk while with the student so you can plan some strategies and resolve the issue as early as possible
https://www.clinedaus.org.au/topics-category/briefing-and-debriefing-182	Briefing and debriefing with a student Wendy Szatkowski – Occupational Therapist So I suppose part of making the student feel comfortable and to give them that background knowledge that perhaps I might have already got by reading through charts or having meetings that they might not have attended. Firstly, I

	would to talk to students when the first come on placements and make sure they understand professional boundaries, also know you know the safety and the risks and that sort of thing, perhaps visiting a client at home or taking them out into the community. So before each time I see a client, I usually have just a short briefing with the student - so what they might expect what where to stand in the home, what the client might present like, what their histories being so taking all of that into context. I think debriefing is an important part of the students learning, it helps them to reflect on what they've just seen so it's in the here and now. It may be as soon as when we jump in the car, when we sit down and I ask the student whether they have any questions about what they've just observed, if there is anything in the forefront of their minds, any questions. I usually will go through their mental state with them, so asking the student specifically, you know 'what did you notice about their speech?', 'what did you notice about their behaviour?' Perhaps whether they noticed if the client was responding to any not apparent stimuli or if there's anything unusual that had come up that even perhaps I'd missed. From there I suppose any other issues that might be arising. So from their functioning, or from there environment, and then we go through the occupational therapy specific domains. I think this also helps to develop their clinical reasoning - you're able to take them through each step of why you did specific things with the client, why i asked particular questions or perhaps might've ended the session early, so it's a really good opportunity to advise them on the steps of why that happened what was going through your mind at the time
https://www.clinedaus.org.au/topics-category/facilitating-reflective-practice-and-self-176	Facilitating reflective practice in clinical education Jodie Booth – Occupational Therapist Reflective practice was something I didn't get that uni. I got it, I was told to do, but I didn't understand it. So when I went on my placements I was very lucky that I had supervisors who were very strong, and made me write down my reflections. That was really tricky for me, so I feel it must be tricky for the students as well. When I started taking students, I followed that same model. So for students coming to Deadly Ears and it might be their first sort of experience in working alongside Aboriginal and Torres Strait Islander people, to try and understand their own culture and how that impacts on providing services to people from another culture. Every week I have set questions that that they have to write down and respond to. They don't have to share all of that with me, I don't make them send it to me, but we certainly discuss the key things during the weekly supervision. And, that if the reflection is tricky for them, then we need to develop that because at the end of the day, when they walk out of a project placement, they're going to be walking out with clinical reasoning skills and not so much clinical skill development, so that if they're reflective practice doesn't develop over that time then they're not getting bang for their buck out of a project placement.

	So I need to make sure that that there are thinking about themselves, they're thinking about themselves in this context, and they think about 'what does this mean for me as an occupational therapist?' and 'what will this mean for me when I'm an occupational therapist working in all sorts of places?', 'what's gone really well this week?', 'what's been really challenging about this week?', 'what are some of those are hard moments that you've had this week - whether that's around cultural aspects or what was interesting?'. Particularly when students first come here and we ensure that they have done their cultural awareness training, that they've been able to have a yarn with different Aboriginal and Torres Strait Islander folk in our program so that sometimes you know they it's this sort of ;A-ha moment' around diversity and Aboriginal and Torres Strait Islander culture and those sorts of thing. Also getting them to think about what you are going to do with this information, how might that inform your project, or your clinical skills and those sorts of things. It's just open-ended questions that give them the space, but also make sure that they take the time and space to do that. Because, when you're seeing client after client that they actually don't have the headspace to reflect on not just their placement but kind of this is where our OT curriculum have got me to now and this is kind of how I might be able to apply that in the future
https://www.clinedaus.org.au/topics-category/conflict-resolution-in-student-placements-141	Key strategies to resolve conflict Julie Gauchwin – Clinical Education Coordinator Q: What do you think are the most important things to do to successfully resolve conflict? A: Well there's quite a few things, and it's again effective communication and then making sure you listen to all parties that are involved, don't just sort of go with any preconceived ideas, be non-judgmental, try to set up any meetings that you have in a non-threatening place, and really again with your communication really find out the real problem is, and then work together to actually try to resolve the situation. I suppose one thing that I've learnt this year you need to be prepared for anything It's absolutely amazing what some of these poor students are dealing with in their personal lives, and it can be quite shocking sometimes but you need to just be prepared for anything, and so you can actually be a good support for the situation.
https://www.clinedaus.org.au/topics-category/the-importance-of-quality-clinical-education-in-149	Student knowledge, skills and attributes Professor Lindy McAllister So preparation for work based learning for students requires generic and discipline specific knowledge, skills and of course, personal attributes don't run across both. It's the generic knowledge and skills that I think we struggle with most. Until recently, when the federal government demanded we be accountable within universities for the development of graduate attributes, which are founded on generic knowledge and skills, and then there are also the discipline knowledge and skills, we didn't really know how students develop these generic knowledge and skills. We assumed that they did, by osmosis or by feedback from their supervisors or their lecturers, but we

	weren't really sure. Now we deliberately build learning opportunities and assessment items into the curriculum that require students to focus on generic knowledge and skills and demonstrate it. Increasingly, those things are part of accreditation requirements as well. A lot of the generic knowledge and skills lend themselves beautifully to interprofessional education curriculum to the placement development and delivery. And one of the things that's happening in my faculty at the moment that I'm leading, is in fact a generic leader professional preparation for practice curriculum that will begin to tackle these things. The attributes are interesting. Students definitely come with orientations and a set of personal attributes when they start their study as a health professional. Some of those can be shaped to a certain extent, through awareness and feedback and punishment. But when you have repeat offenders who don't demonstrate ethical awareness and a strong moral positioning and professionalism, or an incapacity to be self-directed and self managing, it's tricky. I am think that those are the students that we need to direct attention to help them exit from our professions early. I rely on you – as placement supervisors to help me identify those students because it's often in placements that you really become first aware that we have students who are not able to develop the attributes set that we need. Just to touch a little bit on knowledge types. The work of Andrew Titchen and George Hicks has informed my thinking quite a bit about this so propositional knowledge we're all very familiar with - that's textbook knowledge theory, it's what we teach students at university about how to assess and manage deliver interventions and treatments. Then they get to the practice setting and suddenly a whole new set of knowledge is required because they see people doing things differently. Sometimes what's different is that it's not evidence-based practice that they've seen. Sometimes it's professional craft knowledge which is the very automated streamlined knowledge about how you actually get things done. It's the efficiency and automated routines and professional practice. Then there's the personal knowledge, and an excellent place to develop in that placement because students have to be responsible for the welfare of other people. For some of them, that might be the first time that actively had to be responsible for the welfare of somebody else - their clients or their patients. So knowing yourself is a major focus of clinical placements. We attempt to address it though in the classroom as well a placement is an ideal opportunity and probably the only opportunity for the development of professional craft knowledge. So what's the role of work based learning in the development of these knowledges. I'll touch a little bit later on the work of Steven Billet, but I'm increasingly of their view that placements offer the opportunity for students to put into practice what they already know and sometimes they are confused about what they know. I'm sure you all have that situation where you ask a student 'what do you know about X?' and they go mumble nothing. Now of course often that's not true- they have done it, but it's been presented long enough ago that they haven't remembered or refresh their memory, or it was presented in a way that doesn't look like what it needs to look like in this context. Knowledge has to be applied within context, and that's where placement is so important. Out of place and activity comes a whole new set of knowledge in theory which ideally students would take back into the classroom and unpack it and look at it and see how it relates to what they've already been taught at the University - that's the

	missing link I think in working degraded learning. I don't think universities do a good enough job of taking the new knowledge that was acquired through practice and looking at it again in the lens of what was already known and what the literature tells us is good evidence-based practice. You can help students commence that process by asking them constantly what they're learning and how it relates to what they knew but it's really a job that we need to do a lot better. Knowledge skills and attributes are integrated into a very skilled performance, and authentic environments, the most frequent of which is placements. They're not the only authentic learning environments is the site for that integration …
https://www.clinedaus.org.au/topics-category/the-importance-of-quality-clinical-education-in-149	Variables in the clinical education setting Professor Lindy McAllister, The University of Sydney What makes clinical placements or work integrated learning so complex and tricky is all the variables at play. There's the model of placement that's used, and there's still a fair bit of clinging on to apprenticeship model in some disciplines, despite evidence that the collaborative model is a lot more effective for sites and the student learning. The approach to student learning varies from the 'watch and do as I do' approach through to the place of educator being the facilitator of student learning. And then of course students have a great capacity to self-direct their own learning with great responsibility if they're allowed to and if they're well set up to do so. There's peer learning - whether or not we use it or if we do use it our students are well set up to make the most of it. It doesn't come automatically - I think students need a particular set of thinking and skills around peer learning to make the most of it. Then we've got uni-disciplinary placements or interprofessional placements. Interprofessional placements are becoming more common and they're very vexed of course because of disciplinary boundaries, issues around into professional supervision, fear from some supervisors that students will lose critical time in a uni-disciplinary environment and may not achieve the competencies required for registration and accreditation. Jury's out on that, we simply don't know whether putting students into interprofessional placement jeopardise their uniprofessional placements. Opinion and anecdote says it doesn't, but we don't have hardcore evidence of any substance yet. Questions about who leads the placement - is that student level is a clinical educator lead? Issues around the level and frequency, amount and type of supervision that's provided. The agent of supervision - is that the uni-disciplinary supervisor or someone from another discipline that is nominated clinical educator for a batch of four or six students. You're going to be asking for help from colleagues in the department to provide important support to the students and also to me as the clinical educator.

	We can use supervision from non health professionals depending on the sites that the students are placed in - teachers, carers, disability workers and so on in professional supervision. There's student self supervision and peer supervision. They are all a part of a valuable mix of supervision input that students can receive. Then we've got issues of supervision quality - the knowledge, skills and attributes of the clinical supervisors and how those might be developed. The ubiquitous question of time because of the dual roles that clinical educators have with patient care and student learning. The whole plethora of other administrative and professional tasks that they have to complete at the same time - time is always very pressured. When I did my doctoral research I did use a qualitative study of educators experiences being a clinical educator and one of the constant themes was time and one of my research participants described her day-to-day working life as feeling that she always was looking at a clock on the wall and the clock always had an angry face.
https://www.clinedaus.org.au/topics-category/benefits-of-offering-clinical-education-placements-87	Costs and benefits to workplaces Professor Lindy McAllister, The University of Sydney Drawing from the department of human services in Victoria 2007 assertion (without evidence): Clinical placements in hospitals and health services represent significant cost of services. Well in the absence of evidence, I'm wondering what was being costed? Was it supervisor time? Was it patient services? Were those direct or indirect patient services that were provided by the students? That assertion flies in the face of admittedly old data that shows that students are not a cost in terms of direct patient care, and I do acknowledge that the longer a placement goes on the more benefit there is to an organization that host students. There are several studies in physiotherapy that showed real benefits to departments in terms of occasions and amount of direct client care, and then there's a raft of studies that show all the value adding in the indirect patient care, the tangible rewards for clinical educators, and the increased self-esteem and work satisfaction that comes from contributing to the development of future professionals. Now I'm not an Alice in Wonderland, I know how hard supervising students is, so while I might feel great satisfaction, increased self-esteem, I do have days when I want to go home and want to bash my head against the wall. I want to draw your attention to this study because I think at the moment it's the most powerful piece of evidence that we have. It comes from the Mayo Clinic in the US, where they've tracked over many years what happens to clinician productivity when they work with 3-4 students at a time, for nine week blocks, and do this for much of the year. I think one of the things that makes placements unproductive and a drain on resources is where you have just one or two students once or twice a year. Get into the role that they become a real boon to a department that's hosting them. The Mayo Clinic run a very structured program: a good orientation, goal-setting. Students get to observe in the first week and get exposed to patient care in the second week. Throughout their placement, there's a real emphasis on peer learning and other learning activities like developing in-services and running them for the staff. By

	week four or five students are expected to be a 50-percent caseload and at week eight a 75-percent caseload. The final week is evaluation, wrapping up and handovers. Now where students are on placement in multiple collaborative models like this one, the Mayo Clinic data shows that the clinical educator is at least twice as productive as a clinician in the same department with the same caseload but without students. Now it is an American study, is different model. What have we got in terms of recent productivity studies in Australia is not a lot but I'm laying the foundation at the moment for a large-scale grant application. I've already got a number of partners in play with this just a little bit of low-level data and they're all from physio that's where I've started my focus. So in a private hospital, having four students per block for multiple blocks a year adds 14% income to the physiotherapy department from patient care and equates to a third of a clinician. In a private practice students add twenty percent to the bottom line for that clinic and in a mid-sized public hospital physio department they run their outpatient services entirely with student input and the students contribute the equivalent another full-time clinician.
https://www.clinedaus.org.au/topics-category/placement-models-and-approaches-to-supervision-88	The student led health clinic model Question: What are the key components of the Central Queensland University student-led clinic model? Response: In our student led model we have an inpatient clinic here which is actually run by the students. We have students from two different disciplines to do the impact assessment and from that impact assessment the client can be referred to different disciplines. So a student will have knowledge and access to what these different disciplines role within a client's care and pathway model will be. After they go to different disciplines the student is still running the client care and under the direct supervision of that clinician. Question: What were the barriers and enabler when setting up the clinic? Answer: I guess the other thing going back to that again interdisciplinary model is that it can be a challenge for students to think outside of their scope of practice when they're looking at referring to other disciplines, so that's probably an area initially but once the students have been with us for a while it is less of an issue. The other thing would be convincing client sometimes that they get an equal the service coming to a student led clinic versus a clinic just run by both professionals. I guess that you have that promotion in the community and again once a client accesses the service, they feel like they are getting a good service because the students are still under supervision from their clinical supervisors. Question: Now that it's been running for a while, what are the best parts of the clinic? Response: I think the team is probably the best part. We have an amazing team here and like I said before a lot of different health professionals working together. That makes it a very unique opportunity the students. I think probably the students get a little bit more opportunity to see clients more autonomously and they would in other settings

	because everything in the clinic designed around students. So there's extra time to do paperwork and to prepare for the client, there's no rush. Question: How are the outcomes being measured? What are the outcomes so far? Response: There is some research that has been started within the clinic looking at outcomes. So far we haven't got definitive results, but I suppose from direct client contact we can see that we made an improvement on the client that we've got in the clinic - we can see how they've improved from each clinician's point of view and how their chronic condition is actually improving from their journey within the different disciplines. Question: What advice would you give to another service considering their own student-led clinic? Response: Preparation in terms of developing the clinic itself and then once you once you've developed it, taking students on placement is always will be a lot of preparation and planning. Not just on an individual clinician level, but across the whole team. So you know how many students we've got at any given time and that allows us to plan the impacts assessment and those sort of things. Probably the other thing is just as a good understanding of what you want to get out of the clinic so here it's designed around equality model of care but you know they may be other clinics that try to set up from you know if you're a paediatric model or mental health or anything but what you might be outcomes.
https://www.clinedaus.org.au/topics-category/placement-models-and-approaches-to-supervision-88	An example of multiple mentoring in private practice Megan Saunders One of the challenges is that some of our clinical educators actually are part time and we want to actually be able to give the students the benefit of those who have the most experience. So what we've decided that works really well for us - we marry up the clinical educators and we have decided the best way forward for our service now is to have a primary clinical educator and secondary clinical educator. Now it may sound a little bit I'm confusing but it actually works really well because the primary educator will have the student for two to three days a week, and they will be the ones responsible for the mid and interim assessment. The secondary educator will take the student for the other two days they will also do their own mid and interim assessment, and they will liaise with the primary supervisor for completion. It's got some great advantages for the student - they have the benefit of being with two educators in different facilities, different experiences, community, and hostels, nursing homes… and they can see different learning styles. They can see how different educators deal with different situations and we warn the students at the beginning that this is what's going to happen and to actually embrace that that part of the experience and take forward and ask lots of questions.

https://www.clinedaus.org.au/topics-category/placement-models-and-approaches-to-supervision-88	Role emerging clinical education placements Professor Lindy McAllister, University of Sydney These are best established in occupational therapy. I have developed and run some of these for speech pathology and they are successful. So a role emerging placement is defined as a placement which occurs at a site where there's not an established occupational therapist role. There's typically no O.T on site. Students are supervised on a daily basis by someone within that site - it could be the manager, it could be a disability care worker, if it's a community management organization, it could be a client group leader, there's a whole range of possibilities - they also get support from an off-site O.T, often a clinician that's contracted in or works in adjoining service, or they get from an academic clinical coordinator. They work in settings like homeless shelters refugee camps residential homes etc The placements are driven by a range of pragmatic and educational rationales. The rationale is that O.T needs to expand the boundaries of practice, to move away from illness models and institutional focus services, to prevention models and health and social care environments that draw on health promotion, prevention, well-being and community practice. I think these have great potential for other disciplines as well. The data around role-emerging placements is pretty non-existent. What there is, is typically descriptive or anecdotal, but it does show the students value the autonomy, they definitely expand their knowledge of their discipline, increases their awareness but also their skill for collaborative working and it definitely improves their organizational communication critical reflection skills.
https://www.clinedaus.org.au/topics-category/placement-models-and-approaches-to-supervision-88	Service learning placements Professor Lindy McAllister, University of Sydney The keys here are community service, experiential learning, reflection, students taking responsibility and developing citizenship and strengthening a commitment to the common good. Now you may ask why I'm talking about service learning, and it's because I think that we're going to see a lot more service learning type placements and I'm going to describe to you one and that comes from our partner, the Broken Hill University Department of Rural Health. They provide hundreds of student placements a year. Sometimes we have to drag students kicking and screaming to Broken Hill. I've never had one come back without loving it - and why do they love it - because it's a really well structured learning program that not only teaches them a whole set of generic and discipline specific skills, knowledge and attributes, but they have fun. They're integrated into the Broken Hill Community - it's a very deliberative structure to the learning program and they run a number of service learning placements and they based on a range theories - social cognitive theories, experiential learning, complex systems, because communities in which service learning occurs are very complex systems, community engaged scholarship.

	There's a range of research in progress. There's a lot more in the pipeline and they're focusing on stakeholder Outcomes - so what's the benefit of these student placements to the communities and sites to the students to school children or pupils and the aged care residents to clinical educators and to the educational program support staff.
https://www.clinedaus.org.au/topics-category/placement-models-and-approaches-to-supervision-88	An example of a service learning clinic at Broken Hill Professor Lindy McAllister, University of Sydney This is really interesting research in progress, and again this is Broken Hill drawing on allied health. They run student placements in a range of settings, I'm focusing here on schools. The schools are desperate for speech pathology input and OT input in Broken Hill. The school's set the priorities, we deliver. It's mainly oral language literacy development, and for the OTs it's a lot of pre-reading work and fine motor development. These are what we call low risk high volume clients. You wouldn't want student-led clinics or student indirect supervision in high-risk patient settings like acute care and ICU for all the obvious reasons. Students get indirect supervision from their discipline supervisor using a range of methodologies face to face and technology. Students do outreach, so Skype's used a lot. Direct supervision is very small - each student gets two hours a week from their discipline supervisor, another hour a week from the other discipline supervisor. They get supervision and support from the site - it might be the teacher, the principal, the teacher aides as requested. They get an hour of peer supervision a week on a very structured process - student from one discipline are paired with a student from the other discipline and they get debriefing of three hours a week in a group setting. So you can see that there's not a lot of face-to-face supervision. Are people happy? is it working well? Yes they're ecstatic! Students are attaining at or above the level expected on these standardized reliable valid assessment tools, student satisfaction is very high even with the inter professional supervision, which is interesting because there's a lot of literature shows students don't like interprofessional supervision usually, and student satisfaction with peer learning and peer supervision is very high. I think this comes back to really good preparation of the students and excellent learning programs
https://www.clinedaus.org.au/topics-category/placement-models-and-approaches-to-supervision-88	Project placements with the Deadly Ears Team Jodie Booth, Occupational Therapist So over this the time that we've had occupational therapy Deadly Ears program, the range of project placements has evolved as the position has evolved. So first of all we sort of had students really doing some of the service scoping things about what other occupational therapists are doing in terms of what are they providing for Aboriginal and Torres Strait Islander families - really around that broad service coping kind of project. That helped us to understand what was out there and who we as a program needed to be liaising with. Then it has progressed - our operational plan has a defined about the role of occupational therapy then we've been able to find aspects within the operational plan that the students can then develop projects that feed into our outcomes in the operational plans. So an example of that is one that's actually on the website is around the occupational therapy students reflecting on if 'I knew then what I know now' so when we part of operational plan is to look at how university curriculum can really

	be better addressing O.Ts working with Aboriginal and Torres Strait Islander people. We were able to have the students reflect on their curriculum and then suggest back to the University about how the curriculum could be enhanced for them to be better prepared to work in a place like Deadly Ears or the Institute of Urban Indigenous Health. To prepare the project placement it's not like the student arrives on the first day and I just you know make up something out of my head. I often talk to our clinical education support officer and work with them to really define what the placement is so if I can explain it to them as a clinical education support person and they can make sense of it and I know that it's going to make sense to the student. We are very non-traditional O.T service delivery so I need to make sure that the students going to be able to understand what their project will be. Often they'll have a few different projects so that they don't get tired of doing one particular topic, it will be an aspect around sort of looking at the evidence and what's out there in terms of paper-based research but in the area that we work, as an OT working in ear and hearing health, there's not a lot of evidence out there so I also need them to be liaising and consulting with colleagues in our office and beyond to be able to inform their projects. Project placement for this particular setting needs to be clearly defined - the people that liaise with need to be sort of set from the beginning so that they can build relationships with those co-workers and therefore when they need those co-workers to support them for their project they already have that that relationship developed and they can use not only me as their primary supervisor but a speech pathologist, audiologists, health workers, health promotion officers, nurses, anyone else who's around can be a resource for their project.
https://www.clinedaus.org.au/topics-category/preparing-for-a-clinical-education-placement-26	University role in placement planning Simone Howell, Griffith University Question: I was wondering if you could talk about some of those broader issues that the University clinical educators can assist with such as pre-placement planning? Response: Placement planning is something that's been coming up a lot recently and around the theme of assuring quality in clinical placements. So a key role for us is to work with clinical educators prior to taking the student to make sure that all the crosses and checks are in place to ensure that the placement is of a highest quality standard. So around the interpretation or implementation of a tool like the i-clip, if educators are familiar with that one, that's certainly something that we can help unpack and implement in workplace. The other area that we can certainly support prior to a placement commencing is structuring a clinical day with what the students abilities and expectations might be, in line with also what is appropriate in that workplace and is going to ensure excellent client outcomes. We're quite in touch with what students are capable of, the educator can bring to the table obviously their constraint and we work together to try and develop a schedule or a plan that's it's well for both of those things

https://www.clinedaus.org.au/topics-category/preparing-for-a-clinical-education-placement-26	University clinical coordinator support Simone Howell, Griffith University Question: Simone, as a University clinical educator, is there to support both the students and the clinical educator during the placement. I wonder if you could start by telling us a little bit about the support you can provide for the clinical educator? Response: A key way that the clinical education coordinators can support in those early stages of placement planning is in the offering of workshops and education opportunities for clinical educators usually prior to the placement starting. Those workshops typically cover aspects like giving feedback, managing challenging students and some of those core themes that clinical educators are usually quite hungry for information on. During the placement of course we're also able to provide support in a number of ways. This can be over the phone or potentially face to face at a placement site visit and it's typically around things like general discussion with the clinical educator about a student and then unpacking that and pinpointing whether there are any concerns and what those concerns might be. Obviously delivering practical strategies and then how to work with a student if there are concerns. A key role is the interpretation and the marking of an assessment document during that placement - sometimes they can be a little bit ambiguous or clinicians one will be overly familiar with those so that's another way that we can support the clinical educator. Question: I wonder Simone if you could talk now about one of the more challenging issues that you're aware of arising in a clinical placement and how you've successfully supported the clinical educator to deal with that issue? Response: A recurring theme that can sometimes crop up on health professional student placements is around the concept of clinical reasoning skills. Some students have difficulties with that, and I had a student recently that was having some difficulty with their clinical reasoning skills - they were on a paediatric placement and when that situation arises I really try and work with the clinical educator to unpack specific examples and the specific areas that that clinical reasoning is falling down. This particular student was having difficulty with the official transcription and analysing of a speech data with a child, and so I worked with that clinical educator to provide a mock case data for the student to practice with, suggested the student attend tutorials in the workplace on that topic, or if that wasn't possible, to speak with a key University contact to do some extra work, and then working with the clinical educators really to just unpack any other student issues. The outcome there was very successful and the student within a couple of weeks and made significant gains and ultimately passed the placement