Service-learning in rural Victoria: A conceptual model to guide innovative work-integrated learning for allied health students

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Developing Allied Health (AH) graduates who are skilled in responding to public health needs is crucial, particularly in rural areas where workforce shortages and poor health outcomes are common. However, workforce shortages make it difficult to provide rural work-integrated learning (WIL) opportunities to teach these skills. This paper presents a model of Service-Learning (SL) that innovatively employs WIL for AH students while addressing rural health needs. The model was developed based on the experiences of a rural WIL team who implemented over 400 SL WIL experiences over six years. Key aspects highlight the importance of relationship building and meeting the needs of three key stakeholders, namely the community and host-site, students, and the enrolled university. Student support, interprofessional education and evaluation were also embedded in the model. This SL model adopts a flexible approach and provides a useful guide for developing SL for WIL despite challenges in rural areas.

Keywords: Service learning, rural, allied health, innovation, work-integrated learning

As supported by Worley and Champion (2020), there is a need for Australia to develop Allied Health (AH) graduates who not only possess skills core to their profession but also skills to respond to health needs. This is particularly important in rural areas which face the simultaneous challenges of AH workforce shortages, poor health outcomes and less access to services (Australian Institute of Health and Welfare [AIHW], 2019; Humphreys & Wakerman, 2022). However, a paradox exists: how can rural health services host work-integrated learning (WIL), which require time and discipline-specific supervisors, when there is already a shortage of staff and significant health need? Service-learning (SL) as a pedagogy is used extensively internationally but is a relatively new model of WIL in Australian higher education curriculums (Patrick et al., 2019). As such, SL is a viable solution to this paradox. This paper presents a model of SL designed for rural areas in Australia to provide quality student learning experiences, address health needs in rural communities and encourage students to consider working in rural areas in the future.

Although there is no consensus on the definition of SL in Australia (Patrick et al., 2019), the following definition has been employed here:

> A teaching and learning strategy that integrates meaningful community service with instruction and reflection to enrich the learning experience, teach civic responsibility, and strengthen communities. SL is a structured learning experience that combines community service with preparation and reflection... provides college and university students with a 'community

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> context' to their education, allowing them to connect their academic coursework to their roles as citizens. (Seifer & Connors, 2007, p. 5)

Reflecting the reciprocal nature, SL aims to address the needs of the host site/community and the needs of the student. For community partners, SL can contribute to economic, operational, and social benefits (Seifer & Connors, 2007). Participating in a well-developed SL experience can enhance a student's learning as they apply academic knowledge in real world settings, develop a greater awareness of the needs of others, grow as citizens, and learn through critical reflection from their own experiences (Bringle & Hatcher, 1996; Schultz, 1999). The benefit to students includes both personal growth and positive academic outcomes, such as skills, knowledge and attitudes that may be transferrable to any health context (Bringle & Hatcher, 1996; Schultz, 1999). Acknowledging that not all SL is successful, Compare and Albanesi (2023) reported that poorly structured SL can stereotype community members further and therefore does not focus on reciprocity and how both the students and community are benefiting from the arranged experience. Jacoby (2014, p. 20) summarizes the benefits to a community in hosting SL as:

> new energy and assistance to broaden delivery of existing services or to begin new ones; fresh approaches to problem solving; enhanced capacity to conduct and use research; access to institutional resources; and opportunities to participate in the teaching and learning process.

Implementing a SL model in an Australian setting requires an understanding of the contextual challenges which may hinder effective implementation, such as individual university course requirements and reduced access to AH supervisors. While SL is growing in use in Australian education settings, it has not been without challenges. Difficulties in quantifying the success of a SL initiative combined with SL's differences from long-established traditional placement models, can make marketing of SL to key decision makers challenging (Seifer & Connors, 2007). Patrick et al. (2019) noted the need for a more adaptable and customized model to meet various student needs. Langworthy (2007) reported that Australian universities would need to be able to work more closely at a grass roots level to truly address community needs. Lyle et al. (2007) suggested that limitations in internal resources of universities require the development of effective strategies to translate government funding into workforce outcomes through WIL.

To address the paradox that exists inhibiting the capacity of rural WIL, the first SL program was piloted by WIL team in 2015 where students provided needed AH services in a rural primary school that were otherwise not available. After extensive engagement with the schools to identify unmet needs of the primary students and then engagement with universities to identify what students could offer, SL planning resulted in six physiotherapy students supporting primary students with movement, physical education and other school needs. Over time, the SL program has developed and been refined based on the benefits and challenges experienced by the clients, partners and students. Based on these experiences and learnings over time, this paper presents a conceptual framework of the SL model developed.

METHODOLOGY

The paper uses reflective practice and conceptual development by a team of experienced educators in rural WIL. The conceptual model was developed by authors who each have experience in developing SL in multiple rural contexts and have experienced the challenges of seeking supervisors, students, student accommodation and working in under-resourced and isolated communities. All authors are members of the WIL team from the University of Melbourne, known as Going Rural Health (GRH),

comprised of academic educators with a nursing or AH professional background. From 2017 to 2021, the program supported over 400 AH students from various disciplines and universities to undertake SL in more than 22 different rural settings across the state of Victoria. Disciplines included dietetics, occupational therapy, physiotherapy, exercise physiology, social work, speech pathology, audiology, and public health. SL has been established in a broad range of settings that have identified a need to support community members, including non-traditional WIL settings, such as kindergartens, primary schools, aged care services, not-for-profit organizations, and disability services as well as traditional WIL service such as health centers/services. AH students provided services to local communities in line with identified local health needs, as identified by the host organization, through building staff capacity by providing discipline specific knowledge or resources, providing interventions that were either lacking or non-existent in the community, through health promotion activities or by completing needs analyses.

Model Development

Five workshops of 90-120 minutes were undertaken with the WIL team from the GRH program to identify the key elements of SL based on their experiences of facilitating these placements. This process used an iterative approach with the same team members attending all five workshops to enable detailed discussion, integration of concepts and evidence from the literature, and critical reflection to refine the model. The model presented integrates SL concepts according to Seifer and Connors' (2007) definition of SL, evidence from SL literature, adaptation to the varied contexts in rural Victoria, and sustainability to ensure reciprocal outcomes for students and stakeholders. While not formally evaluated, the model presented is based on more than 10 staff members using the approach and adapting it over several years to provide 400 SL placements. Experiences of this approach taught the team about what worked, what approaches did not work and what was key to SL placements as described by stakeholders.

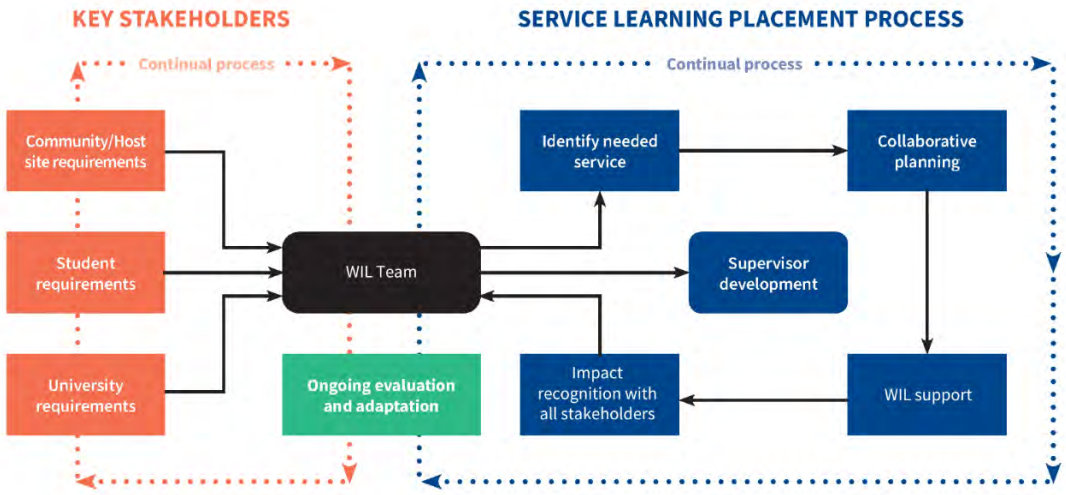
FINDINGS

As illustrated in Figure 1, the elements identified in the SL model included the: (i) community / host site requirements; (ii) student requirements; (iii) university requirements; (iv) identify needed service; (v) collaborative planning; (vi) WIL support; (vii); impact recognition; (ix) supervisor development and, (x) ongoing evaluation and adaption. The key to this model is the interaction between these ten elements and ensuring they are all undertaken simultaneously to provide a flexible approach to developing SL in the rural WIL context.

Community/Host Site Requirements

Mirroring community centered practice and the notion of no one being the expert, it is critical that the staff and/or volunteers from the host site are central to identifying needs. Programs must be responsive to resource gaps or needs and must not be assumed. Host sites co-drive the SL planning, service provision and student guidance, identifying needs, what students can achieve and how services can be provided. Support for host sites may occur in multiple ways, including staff well-being initiatives, professional development and/or the delivery of practical solutions to student supervision, such as implementation of a collaborative supervision model which reduces the reliance on discipline specific supervisors often seen in more traditional WIL approaches. However, investment is required by the host site and commitment to supporting students and health outcomes can create additional work for these under-resourced services. In some sites, placements were not continued because the host site was not able to provide enough student support.

FIGURE 1: Service-learning model of a work-integrated learning program in rural Victoria.



Student Requirements

Rurally based SL has the potential to facilitate student growth through enhancement of rural practice knowledge, developing discipline specific skills, and growing awareness of themselves as citizens within a community. To provide authentic WIL opportunities, it is essential that the learning needs of the student are identified early, well-understood and matched accordingly to SL. It is important to note that SL may not always be appropriate; as scope of practice and service continuity must be considered. When SL is considered appropriate, learning opportunities relevant to the students' WIL setting are sought in order for students to have skills and interest to address the identified needs. While students were often skeptical about clinical learning at the outset, feedback from students usually indicated a sense of achievement at the end of their SL experience.

University Requirements

The connection between education and industry is essential to promote innovation. In consultation with respective academics, identification of the curriculum needs of the enrolled university are required to be made known to the WIL team early in the process. These needs will ultimately determine the appropriateness of this innovative approach to WIL and can guide the SL design. The team found it was necessary to heavily promote SL placements as some universities were hesitant about the learning outcomes for students. However, after participating in the SL approach, universities were supportive of future SL placements.

Identify Needed Service

Identifying the service need is the first of four processes in SL. Needs identification occurs through the development of partnerships with community organizations who are working in communities that experience a significant level of disadvantage according to national and state data (ABS, 2023; ACARA, 2023; AIHW, 2022). Staff and volunteers from community organizations, such as schools, community neighborhood houses and not-for-profit community service agencies, are consulted as valued experts of community's complexities, needs and service gaps. Lack of access to appropriate, accessible, and affordable AH supports, for instance pediatric AH services for children in rural areas, was a common theme in the communities where SL programs were established.

As SL developed, commitment to ongoing, effective communication with community-based staff/volunteers ensures the SL program integrates students' coursework and scope of practice into needed service projects. As students apply their coursework through agreed service deliverables, such as therapy, assessment, development of resources and staff education relevant to their AH discipline, gaps in service delivery can begin to be addressed. Concurrently, students develop an understanding of their professional roles and civic responsibilities within the context of the community where they undertake SL. Students are also able to provide feedback on what they would like to address and support during their placement to ensure that they also have the interest and skills to address the gaps in service delivery.

Collaborative Planning

Reflecting the structured learning experience of SL (Seifer & Connors, 2007), diligent planning and preparation is needed to implement a SL learning experience where students can assist by applying their coursework and own skills through practical community service. Once agreed, the unmet community need identified by the host site remains central in planning. Reflective of typical practice settings, competing un-met needs often exist and prioritization must occur. Planning and sustainability measures need to be considered in the SL context due to the student-led nature of service provision. Strategies to ensure that end-users are not further disadvantaged by SL may include student-led: (i) capacity building initiatives (e.g., staff training and education); (ii) utilization of supervision and delegation frameworks (e.g., working with AH assistants); (iii) stand-alone projects; and (iv) additional student rotations to provide follow-up and/or the continuation of service.

Mandatory requirements are identified, which include the compliance of student-related governance procedures and associated requirements (e.g., a current Working with Children's Check). Students may also benefit from direction from the host site to facilitate site-specific orientation in advance (e.g., vision and value statements, demographics of end-users, staffing and/or volunteer profiles). Resources must be assigned at this stage to develop agreed roles and responsibilities within the embedded collaborative supervision team. Collaborative supervision models are a strategy to reduce the supervision load on any one person and usually comprise of a discipline specific supervisor, an operational contact person and an interprofessional mentor. Countering the paradox, any identified supervisory needs are identified and solutions are sought should the host site not be able to provide clinical supervision themselves. The WIL team provide resources for paid external supervision where necessary. Schedules are designed to ensure that sufficient opportunities are embedded into the WIL experience to facilitate students' reflection on their experiences while living and working in the local community. Reflective activities were important to the process and were planned. These may take the form of formalized written 'learning logs' and engagement in peer assister learning (PAL) group discussions with other rural SL students, facilitating deeper learning, exploration and development of their civic roles. Reflective practice may also be implemented during weekly check-ins and during debriefs with students as the students are provided with an opportunity to think and reflect on their experiences. Written information depicting these planning decisions is disseminated to students to guide WIL preparedness and communicate expectations.

Work-Integrated Learning Support

WIL support is a continuous process in SL. Support for students may include the provision of accommodation, financial support, mentoring, social connectedness and/ or self-care. Student engagement activities are also built into the model to address any potential feelings of isolation. It is essential that the student's capacity to take care of their own wellbeing is developed within the WIL construct, especially if placed away from home and/or support networks for the first time. Wellbeing

is further supported through facilitation of interprofessional sessions specifically aimed to showcase the importance of self-care being central to good practice, such as resilience education. The support from the WIL team to all stakeholders and particularly the students was found to be essential.

Impact Recognition with all Stakeholders

Impact recognition has been critical to supporting host sites and students to reflect on achievements in the SL context, associated learnings, and the impacts for the end users. Stakeholders, especially students, want to know that contributions are valued. Outcomes for the host site, the local community, supervisors and students have been discussed and documented. Strategically, it is important that the impact of each member of the collaboration needs to be acknowledged in an attempt to avoid burnout and to commence the 'open' conversations required to guide future service. Recognition strategies have included increased skills for the host site and supervisors, positive feedback from the community, and the co-authoring of content for local media outlets, conferences, magazines, and newsletters. The practice of co-authoring content provides an opportunity to recognize the input of all partners, including host sites and students.

Supervisor Development

It is important for supervisors to be supported to have the capacity and required skills to provide mentoring and supervision to students that may cover a variety of complex issues. Consistent with the unique nature of SL, supervision training is tailored to support clinicians in their education role within SL. Supervisors are educated regarding the different practices within the SL environment including a strong focus on reflective practice as a key learning tool for students. Whilst in demand, supervisors report that they value the opportunity to be involved in SL as it provides them with; (i) involvement in education; (ii) an opportunity to be involved in a community program with local benefits; (iii) co-design opportunities; (iv) a break from other clinical work; and (v) skill development.

Ongoing Evaluation and Adaptation

There are benefits for teams who enable open discussion on how to continuously improve. Ongoing, effective communication between host sites, students and universities has the potential to identify barriers changing needs as they emerge. Ongoing reflection and adaptation can occur through regular scheduled meetings with students, supervisors, host site staff and university staff. Once an SL experience has finished, a post placement process of reflection occurs to review and evaluate the strengths, challenges and future learnings from each experience. This process can identify where: students had not performed to expectation, sites felt a burden, learning was not always optimized, the work was too difficult for students, and any other issues that may arise. Strategies are developed to respond to these issues, these may include the clarification of roles, scaffolding student tasks, the revision of WIL aims, and/or the development of a communication plan.

This model has been designed in a way that all elements are to be undertaken continuously, this is central to it being effective. Communication, relationship building, reviewing, discussing, clarifying and collaborating occur before, during and following the WIL. This assists in collectively addressing issues, including sudden staff changes, pandemic-related requirements, supervision issues and/or a lack of student accommodation. The model facilitates the development of a shared responsibility to make SL work for all stakeholders and adaptation to circumstances must occur as required.

Case Study

Two case studies are provided to demonstrate the model in situ. The first case study (Box 1) is provided to illustrate the model components in the implementation of the SL model.

BOX 1: Case study 1 – Key components of the service learning model in implementation within a service.

A pilot Occupational Therapy (OT) and Physiotherapy (PT) SL WIL was implemented within a rural Victorian state primary school in 2021.

Service needs were identified by school staff who understand the school community's complexities and needs. The rural school community has a history of vulnerability resulting in cumulative high needs related to children's physical, emotional and social wellbeing. Staff were also stretched in their roles in supporting children and identified difficulties in accessing AH services for their students. Discussions between the school staff and the WIL team agreed that university students could assist to address some of the access barriers and health needs of school children, particularly OT and PT students, through an onsite AH service.

Collaborative planning was facilitated by the WIL coordinator and involved the school's leading teacher and external OT and PT supervisors who became the collaborative supervision team. Relevant student tasks and staff roles were agreed upon, where the school identified what was needed and could be provided in the school context, and the WIL team identified student scope of practice. The WIL coordinator then consulted university placement teams to match OT and PT students to the SL experience. Student requirements were considered, including year level, assessment requirements, accommodation, discipline-specific and inter-professional skill development, and appropriate clinical supervision. Paired student allocations were chosen to promote PAL opportunities and peer support. An online student briefing prior to commencement ensured the SL model was understood, expectations were aligned, and students felt prepared for living and working in the local community. The health needs identified by the school remained central throughout the planning process.

The presence of PT and OT students at the school provided a platform for early intervention for students who had not accessed AH services previously and may not have had alternative opportunities. This included screening, therapy, and referral (as required) to support child development. During the SL experience, OT students implemented a sensory pathway to assist children to calm their emotions and regain concentration while transitioning between learning activities. PT students led group-based interventions during Physical Education (PE) classes and scheduled "brain breaks" to improve balance and coordination skills at a group level, and provided targeted interventions for specific children in a group context. Individual observation, assessment and therapy interventions were provided to children with consent of guardians. Students consulted carers and teachers to discuss assessment findings, interventions, and recommendations. Students also refined the school's AH referral form and provided education to school staff about PT and OT roles within the school context, to support staff to refer children to the service. Detailed schedules were used to ensure regular opportunities for students to reflect, debrief, receive timely feedback, and develop skills in clinical applications.

WIL support was provided to students by the WIL team throughout the SL experience. Weekly mentoring meetings sought to ensure physical and emotional needs were supported and that students were on-track with their learning goals. Reflective practice was implemented into student mentoring and debrief meetings to facilitate deeper learning, understanding and development of

their civic roles while providing services to the school. Operational support was provided to the school to assist smooth running of the placement.

Impact recognition was completed with all stakeholders. Benefits to children were observed through comparison of before-and-after assessments and observations. Benefits to staff included increased knowledge of PT/OT roles and support available, and confidence to refer children to the service. Teachers also experienced a "lightening of their load" when students facilitated group-based interventions. All university students passed the relevant university assessments.

The pilot PT and OT SL experiences provided foundation for further needed service delivery and handovers were filed for future OT and PT students. By following the processes within the SL model, AH services were expanded at the school the following year. Sustainability of AH early intervention is supported through the model providing Education staff with capacity building and tools to identify AH needs early, implement therapy recommendations, and use appropriate referral pathways. Staff also have awareness of the value of early intervention which can facilitate advocacy for ongoing AH support in their school. Supervisors with pediatric, discipline-specific and SL skillsets were difficult to recruit but the WIL team used local networks to secure supervisors and supervised where necessary. Supervisors were private PT/OT pediatric clinicians with student supervision experience and were employed by the university. Supervisors received mentoring from the WIL team in the SL model and were supported to attend professional development and networking sessions.

Evaluation and adaptation were continuous within the collaborative supervision team and included debrief discussions and surveys. Key improvements were identified to optimize service delivery at the school, including effectiveness of student-teacher communication, and mutual understanding of teacher and student roles. All aspects of the SL process and collaboration with key stakeholders were ongoing. Underpinning the model were strong working relationships and commitment to keeping the school's needs central.

The second case study (Box 2) is provided to illustrate the impact of a WIL placement. This case study identifies the impact of physiotherapy students in a rural aged care facility.

BOX 2: Case study 2-Impact of service learning model in a community.

In 2017, the WIL team worked with a local rural health service to develop SL placements for physiotherapy students to meet the needs of the local community. The project involved five students for 10 weeks where students were asked to develop and implement a project to reduce the waiting list and provide low-risk interventions to patients in the aged care wing.

The first rotation of students worked with their supervisor to develop strategies to reduce the waiting list and identify low risk interventions for older adults. Subsequent rotations of students implemented systems to reduce the waiting lists and provide care not previously provided. This reduced workload pressures on physiotherapists and provided increased care for patients at the health service. The physiotherapy students implemented a project that reduced waiting lists from three years to less than six months. This gave the local community improved access and provided valued support to the department for this needed local service. These students also developed and

implemented appropriate interventions that had marked benefit to individual clients. Feedback from the health service staff indicated the value of the program:

> A physio student worked intensively with an elderly woman in aged care with cognitive impairment who had not walked unaccompanied for six years. Through student assessment, she now walks independently (using an aid) from her room to the lounge

The integrated collaboration with health services provided ongoing education and mentoring to staff, supervisors and students that were observed to have positive impacts and contributed to organizational change. A staff member from the aged care facility commented:

> It has been very beneficial for the staff and residents having the students with us. The residents that the students have worked with have had an improvement in their lifestyle with us and also their day to day activities. Your program has helped to fill a need that this facility was lacking due to a staff shortage in the allied health fields. The supervisors have done an excellent job with the students keeping them on track with their requirements for this placement as myself and the nursing staff are not qualified to do this for the students. I have also noticed the students enjoy the autonomy that is expected of them in this placement with us. We have enjoyed having the students and their supervisors with us, and hopefully we will continue to be part of this program.

The WIL team has continued to work with the health service to further expand their allied health placements and most recently the service hosted an inter-disciplinary placement involving physiotherapy, speech pathology and occupational therapy students supporting the implementation of the Montessori approach in the aged care services. The health service remains committed to ensuring allied health students have a positive experience, evident in the opening of a modern education facility and new purpose-built student accommodation.

DISCUSSION

This conceptual model, derived from experience of over 400 SL based WIL experiences in more than 22 settings, provides a useful guide for WIL teams who are looking for innovative and responsive approaches to implement WIL. Given the WIL shortages that exist (Thomasz & Young, 2016), SL provides an opportunity for WIL teams to work in new sectors and organizations that would ordinarily be unable to host students, therefore expanding their reach into 'untouched' and potential host sites. It also presents an opportunity to model our civic responsibilities of being a health professional amongst our future workforce and exposes students to a breadth of practice settings beyond acute care. Such approaches to WIL also have the potential to counter the paradox that exists in rural settings and highlight the potential for reciprocal benefits to host organizations' communities and to students. While some may challenge that the ten elements identified in this conceptual model are not unique to SL, this model is supported by the literature and then advances a process for how these might be implemented. This conceptual model offers a step-by-step process for those who are new to SL and are interested in trying something new in the rural WIL context.

Consistent with SL literature and what SL conveys, it is the notion of reciprocity differentiates SL from more traditional WIL approaches. Reflecting the 'service' in SL, this innovative approach to WIL can

respond to workforce shortages, gaps in service provision and local community needs (Downman & Murray, 2017; Jacoby, 2014; Seo et al., 2020). When done well, unmet needs are identified by the community itself and should not be presumed by people removed from the daily challenges to avoid any savior like connotations (d'Arlach et al., 2009). In response to university needs, SL can provide additional or alternative WIL opportunities for students (Valencia-Forrester et al., 2019). This is of particular interest for universities, especially if they are experiencing WIL shortages in particular practice areas or cohorts. Given the known links between WIL and intention to practice (Mitchell & Rost-Banik, 2019), the application of this conceptual model can also provide our future AH workforce with different and a more diverse WIL opportunities and may assist them in making informed choices regarding future practice (Davis, 2018).

SL encourages students to become more aware of their own privilege, human rights and awareness of others' needs (Krain & Nurse, 2004; Salter et al., 2020) by providing students with exposure to potentially new opportunities and environments. Students engaging in SL alone does not result in this transformation and focused reflection is required to foster student growth (Eyler et al., 1997; Li et al., 2019), there is a risk that this vital component is neglected in the model and the model is not implemented in its entirety. Reflection assists students to identify strengths of rural communities and adaptations required to overcome the known health disparities. SL in the rural context has the potential to provide a transformative experience to the students, that will alter their perspectives and continue advocating for equitable access to rural healthcare once they are registered health professionals.

The development and maintenance of effective stakeholder relationships are critical in SL; an ongoing commitment to communication and collaboration with stakeholders is required to facilitate all aspects of the SL approach (Jones et al., 2018). As reflected in Figure 1, this conceptual model of SL needs to be implemented in its entirety and via a continuous approach. Given the dynamic and everchanging nature of stakeholder relationships, it is acknowledged by the authors that the implementation of this model may be easier in rural areas because there are fewer players and less competition in the WIL context (Thomasz & Young, 2016). While this may be the case, it is also important to note that the stakeholders in the rural context are experts in their communities, they are well aware of the service context, needs and associated gaps. However, the need to implement strategies to support consistency, reputation and trust in rural communities are critical in SL and if any relationship is strained, it will impact all WIL in the community (Jones et al., 2018; Kirby et al., 2018; Salter et al., 2020). Further, differentiating itself from traditional WIL, the WIL team in SL need to prioritize and invest in the time required to develop rapport with staff and/or volunteers. The student-led nature of service provision in SL must be sustainable and these rural communities need a reliable team to step in and/or step up when things do not go to plan (Jones et al., 2018).

SL is not without its challenges. Despite best intentions, students can be a burden to staff and add extra work. Ethical issues may arise when the unmet 'service' needs cannot be met via SL and tensions may arise if there are disparities between community need/s and the fulfillment of institutional requirements (Hall et al., 2018). Every community is different and there is a risk that WIL teams may not implement this conceptual model in the way it is intended;, reputations and relationships are at stake if SL is not adapted to the unique and ever-changing needs of rural practice. Mirroring the ongoing reflective process that this SL model illustrates, it is imperative that WIL teams in SL remain committed and engaged in the rural communities that they are collaborating with, despite the challenges. This can be particularly hard for the WIL team, especially if the collaboration is not being reciprocated by all parties. When all else fails, the WIL team may need to exercise the confidence required to discontinue relationships to not further add the health disparities unique to rural practice.

Whilst the collaborative supervision model has the potential to build the capacity of WIL in an already stretched workforce (Bartholomai & Fitzgerald, 2007; Hanson & Deluliis, 2015), strategies to develop clear roles and responsibilities may not always go to plan and supervision models may need to be reviewed earlier than expected. This may result in the reassignment of roles and/or the recruitment of new supervisors, resulting in unavoidable disruptions for students. Whilst all attempts may be made to recruit an appropriately skilled supervision team on-site (Wenham et al., 2020), issues sourcing supervisors continues to be a challenge due to the workforce shortages in rural practice and rising supervision costs. Strategies such as telehealth supervision models may be implemented on such occasions which require universities and their governing bodies, to be open to innovation, creativity and change. This can be a limitation of SL in the Australian context. Key to this is strong relationships with all partners to adapt to supervision arrangements and struggles.

Due to the developmental nature of our model, limitations of this conceptual model include that it is in its infancy stage and further evidence is required to demonstrate efficacy. The model has not been formally evaluated, however, indications from over 400 SL experiences, continued community-partner commitment over time and expansion with new partnerships to implement SL indicates appropriateness and acceptability of the model. The authors recognize the unique opportunity that exists to measure the impact now that this model has been conceptualized and amendments to an existing survey to capture the attrition of student outcomes in SL are in motion. This conceptual model does challenge traditional education and usual medicalized models of WIL, however, it also provides an opportunity for teams wanting to try something different and move into rural settings with low workforce and high community needs.

CONCLUSION

This model of SL has been designed for rural areas in Australia to provide quality WIL experiences, address local health needs and encourage students to consider working in rural areas in the future. SL models differ from more traditional WIL models due to the underpinning reciprocity principles. SL has the potential of delivering benefits to the community via the provision of service that would otherwise not have been available, creates exposure to a more diverse areas of practice for AH students, creates much needed WIL opportunities for universities and can assist recruitment into rural health career pathways. While there are various concepts that already exist in the literature, the model and case studies presented in this paper highlight how SL can be effective in a rural setting where resources are scarce and needs are high. The model further emphasizes an investment in building relationships, staff wellbeing, creativity and citizenship. WIL in the rural SL context facilitates relationships among communities, services and universities, provides opportunities for students to use their skills in a safe, reflective learning environment, and provides opportunities to learning, collaboration and addressing local needs. Focusing on developing a comprehensive and holistic program while also focusing on the development of relationships with various stakeholders is central to the model. Future evaluations of the benefits for the host site and the community as well as the students are in progress.

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