FINAL REPORT

RURAL CAPACITY BUILDING PROGRAM – 2012 INTAKE

HEALTH EDUCATION AND TRAINING INSTITUTE

ATTITUDES OF HOPE, CARE AND JOY: STORIES OF COLLABORATIVE LEARNING MENTORS.

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ABBREVIATIONS

ClinConnect	Web-based application for managing Student Clinical Placements
HETI	Health Education and Training Institute
MLHD	Murrumbidgee Local Health District
NSW	New South Wales
RRCBP	Rural Research Capacity Building Project
Speechie	Speech Pathologist
SpICE Model	Specialist Integrated Community Engagement Model
Uni	University
WNSWLHD	Western New South Wales Local Health District

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ABSTRACT

This study explores the role collaborative learning has in building student fieldwork capacity in rural, remote and Indigenous communities. It examines community mentors' stories of supporting speech pathology students in rural NSW communities. These mentors provided this specialist student support as part of the inaugural Specialist Integrated Community Engagement - SpICE project in 2012.

Australia has significant examples of inequality in health and wellbeing, with significant disadvantage still evident in rural, remote and Indigenous communities. Preparing a future health workforce to be equipped to deliver healthcare that provides inclusive care is necessary. Traditional placement models, utilising discipline-specific supervision and in clinical contexts, may be insufficient to adequately prepare students for the collaborative practice needed to redress these inequalities. Examining alternative student placement models, like SpICE, is therefore necessary to determine the legitimacy and value they have in preparing health students for collaborative and inclusive care provision.

A narrative inquiry was undertaken into the mentors' experiences. This methodology was chosen to enable the transfer of the mentors' uncaptured knowledge of their experiences and attitudes. Additionally, the partnerships developed through narrative inquiry lay the foundation for the uptake of research into practice. It is this application of research that is necessary for collaborative approaches like SpICE to evolve and progress.

The research findings convey the attitudinal narratives that these community mentors share that overcome many of the barriers to collaborative learning and endeavour. Their stories speak of 'hope' for a better future; 'care' about providing a meaningful learning experience; and 'joy' in what can be accomplished in a collaborative learning context.

The significance of these findings is that non-traditional, collaborative placements offer not just an 'alternative' placement model to shape our future health workforce. Importantly, they also provide an approach that teaches about 'care' in health-care, and result in broader and more sustainable benefits for rural, remote and Indigenous communities and those who deliver specialist services within them.

Keywords: collaborative learning; rural, remote and Indigenous communities; health workforce preparation; mentor attitudes; narrative inquiry.

EXECUTIVE SUMMARY

IMPLICATION

The adoption of collaborative learning models by rural and remote health service providers, can build the capacity and quality of student clinical placements. Additionally, the participation of community members in the preparation of students for rural and remote practice is a practical method of engagement that builds partnerships and locally relevant approaches to health care delivery.

BACKGROUND

Traditional approaches to student clinical education are exerting an ever increasing pressure on health service clinicians as they try to balance the provision of quality learning experiences with high service demands. At the same time, rural, remote and Indigenous health and wellbeing indicators continue to lag behind those in metropolitan areas. Investigation of alternative approaches to student education is

therefore necessary if health services are to continue to participate in the preparation of a health workforce that can adequately address the current and future needs of rural, remote and Indigenous communities.

Health service and other social policies recognise the value of partnerships and whole-of-community approaches to building healthy and resilient communities. These policies acknowledge the contribution communities can make to the evolution of health service provision including the education of the future health workforce. However, from a clinician's perspective, there is still little guidance on how to deliver services and train students collaboratively. Nor is there substantial evidence to validate the collaborative approaches that have been attempted.

This study seeks to contribute to the evidence base by critiquing the ability of the Specialist Integrated Community Engagement Model (SpICE) to build student placement capacity while simultaneously developing community partnerships. This investigation into community participation in the preparation of health students, particularly examines the validity of this type of collaborative learning approach that has a focus on developing aspects of *care* to supplement technical and discipline specific skills.

METHOD

A qualitative, narrative inquiry research project was undertaken with 6 of the 27 Community Mentors who participated in the first roll-out of student placements using the SpICE Model in 2012. Through interviews, mentor stories were collected about their student support experience. An analysis of their stories and further collaborative investigation of the preliminary findings was conducted to determine the relevance of what they shared. Finally, their stories were re-presented in 3 narratives that describe and evaluate the attitudes they conveyed as mentors. Further discussion of these narratives describes the relevance of not only of sharing the stories but also the benefits of collaborative learning to students' rural and remote practice preparation and communities alike.

FINDINGS

The mentors' narratives portray the positive attitudes *of hope, care* and *joy* that they contribute to the collaborative learning experience. It is important to share these narratives, as they contain both evidence for, and approaches to, building capacity for rural student placements. The narratives also suggest that collaborative learning provides inclusive and sustainable benefits for rural communities.

One of the key findings in this study highlights that health specialists need to develop both technical and positive attitudinal skills to deliver quality care. The findings suggest the reason that the mentors may be best placed to teach health students about attitudes to care, is because they are not constrained by an expectation to teach technical skills. They can also *contextualise* the importance of attitudinal learning by connecting the students to people who are often obscured in traditional clinic-based placement experiences.

The benefits to communities of participating in student education are also discussed in this report. Of significance is the evidence that collaborative learning facilitates 'specialist knowledge' sharing across many sectors of the community. This serves to equip rural, remote and Indigenous communities with the type of knowledge that helps them be informed contributors to current as well as future health service planning and delivery. Additionally, it demonstrates to students that rural and remote practice does not necessarily equate to isolation.

RECOMMENDATIONS

The positive attitudes of the mentors in their narratives show a way forward on reducing inequality that does not ignore the seriousness of the issues facing rural, remote and Indigenous Australians. It also demonstrates the commitment many people make to actively participate in striving for beneficial change. By sharing their narratives, the mentors have set the scene for ongoing critical review of assumptions that limit the development of a truly caring health workforce.

It is recommended that:

1. There is ongoing critique and discussion by all who are involved in health student preparation about what constitutes legitimate health workforce preparation.
2. That consideration be given to modify student placement policy and systems (like ClinConnect) to better accommodate collaborative learning methods.
3. That health services explicitly give preference to applicants with collaborative learning experiences when recruiting to rural and remote health positions.
4. That SpICE funding is expanded and cross-sector partnerships are formalised to enable broader delivery across rural and remote health districts as an effective and practical model of engaging communities in the training of the health workforce.

INTRODUCTION

This research story started the day I had to hand over my students for a placement with the Aboriginal Medical Service in a small regional centre. That's right, I thought of them as 'my' students. They were of my discipline. They were studying in my town. I had prepared them for this placement. I had even driven one of them the three hours to the placement, talking about life and music, albeit awkwardly in trying to cross the generational and supervisory-student divide. However, the process of taking the students to their first host organisation for supervision by 'others' triggered a similar anxiousness as I had had when I left my eldest child for his first day of school.

I could not understand this feeling of anxiety, particularly given that I am by no means a clinical educator who stays in the clinic. Moreover, I have been taking my students with me to learn about speech pathology in preschools, schools and small communities for the 20 plus years of my professional career. This discomfort had me questioning whether SpICE,[1] this new, collaborative learning approach was going to work; whether my precious students would be okay; and what I was going to do with myself until I was needed again?

My discomfort on this first day of SpICE was not so much about SpICE's ability to honour collaborative learning methods. It was more about realising I needed to examine the uncertainty that there was value in 'inviting' non-speech pathologists to be active players in the professional training of my discipline's protégés. There was a tension here for me as a supporter of collaboration but also an advocate of promoting my profession's hard fought for identity and reputation.

So while it was with some trepidation that I proceeded to relinquish my students to their host organisations, it was also with a great deal of curiosity. It was a curiosity about how the organisations' mentors, who were collaborating in SpICE, went about the task of collaborative education. These Community Mentors represented a group of people who seemed to easily traverse the cross-sector and interprofessional divide. It seemed worthwhile to explore their preparedness to participate in collaborative learning.

This experience made me realise I was venturing into new territory—unprepared. I sensed that there was a need to better understand what is necessary to properly prepare health professionals to address inequalities, particularly in the rural and remote health landscape.[2-5] I wanted there to be more guidance than just policy directives that aim for more 'generalist' undergraduate training; [2] or clinical education research that is still dominated by discussion about developing student *technical* competency. [6-8]

So I embarked on this research journey, initially to evaluate the rigour of the SpICE Model (see Appendix 1) to build capacity in student fieldwork placements. What also resulted, however, was a critique of the underlying assumptions informing health workforce preparation. The following paper is directed to those interested in holistic health workforce practice and education, particularly those who strive to put the *care* into healthcare.

BACKGROUND AND RATIONALE

I started my professional training back in the eighties. As a very young adult, with little life experience, I moved from a regional town to the city and put the next 3½ years into learning how to be a speech pathologist. I had no idea what a speech pathologist was, just a vague idea that I might be like Anne Sullivan, the teacher who helped Helen Keller learn to communicate. I spent my university days learning the theoretical and technical aspects of how to be a speech pathologist. I went on placements that taught me how to apply my university knowledge in a practical way. I listened and watched the speech pathologists who contributed to my learning and yearned to be like them, a 'proper' speech pathologist who could do the job with confidence and without hours of preparation.

In my last few weeks of university, I had the opportunity to attend a national speech pathology conference. I got to sit next to some of whom by then I knew to be the famous names of the speech pathology world. I was inspired by the knowledge represented at that conference and quite daunted by the passion with which the delegates had sought more and deeper knowledge. I could hardly believe that I was about to be inducted into this professional body. I was about to be received into what I saw as an amazing club.

Then before I knew it, eight years of being a speech pathologist had passed worked entirely in rural communities. During those eight years, I felt there had not been a single Helen Keller whose life I made better through the practice of speech pathology. Instead, being a speech pathologist was just a constant battle with managing waiting lists, arguing for a share of ever tightening budgets and circumventing Ministerial complaints about the inadequacies of the service. And there were the students, who out of a sense of duty to the future of my profession, I supervised in their application of theory into practice. I became proficient at creating an environment where they could practise their evidence-based knowledge while I protected them from the compromises they would have to make in the real world—just like had been done for me when I was a student.

Over coffee one day, my aunt told me how much she admired me for the work I was doing saying, "You are such a caring person to do what you do." My response to her of, "It's just the job I'm paid to do" revealed nothing of the doubts and the questions I was about to have. But it revealed a lot about how complacent I had already become about what it meant to 'be' a speech pathologist. I asked myself exactly how I was being 'caring' towards the people I was paid to serve. How exactly was I trying to change any of the inadequacies of service provision? How exactly was I preparing a future workforce to redress social injustices? In fact, what exactly did I know about social injustice, when really my focus had been on being proficient at managing the demands of my workload, not on *why* I was doing my work in the first place?

Given that I undertook an 'applied science' university degree, it should be no surprise that the emphasis of my undergraduate training and my subsequent practice was on the efficient and precise delivery of interventions to address impairments of communication. I learnt to assess and analyse communication skills in terms of numeric scores and deviations from the 'norm.' In planning my therapy, I referred to an evidence-base derived from quantitative research. I monitored the effectiveness of my treatment using scaled outcome measures. I was accountable for my effectiveness by reporting changes to the length of waiting lists and the numbers of clients seen in a month.

Habermas (1971),[9] a prominent philosopher, describes the type of empirical approach I was using to 'know' how to be a speech pathologist as a way of *knowing* driven by a *technical interest*. The limitation of relying on this kind of 'knowing' to deliver health services is that it focuses attention on science and its method, as opposed to the kind of social and cultural knowledge needed to work intersubjectively with people. Inadvertently, I was stuck in a cycle that reinforced the technical (with things like winning quality awards for service delivery efficiencies), at the expense of developing the type of knowledge that would have put *care* at the forefront of my practice.

After my aunt's comment, I did change how I practiced speech pathology. I adopted a client-centred focus. I advocated for services in rural communities that were more responsive to local need. And I committed to providing students with workplace learning that was safe but real. I was now being more informed by the type of knowledge that Habermas (1971)[9] says is driven by *practical interest*, where client perspectives and situations are considered and actions are developed from consensus.

In paying more attention to people's situations, I became aware of the evidence suggesting that a technical focus, while providing high quality services, is not an adequate approach to providing healthcare that cares for *all* people. There is still alarming evidence that we are failing to reduce the disadvantage faced by many Australians. In relation to child wellbeing, the Australian Early Development Index (2012)[10] provides evidence on how Australia's children are developing. The information most recently collected, indicates that nearly 15% of Australian children need some additional support from specialist services (allied and other health services) in order to achieve positive life outcomes. The data from this report shows that poorer childhood development progression is still seen distinctly in children from rural and remote locations, children from families with lower socio-economic status and in Indigenous children. This kind of inequality in Australia is costing $22 billion per annum according to The Australian Research Alliance for Children and Youth (2010).[11(p54)] They state that this cost is the result of the long term effects of early disadvantage like reduced skill levels, suboptimal workforce participation and productivity, and increased welfare dependency.[11] The Plan identifies that the complex way in which children develop and learn requires collaborative and whole-of-community action to promote wellbeing.

While there is an indication in policy of an aspiration to deliver on *collaborative* and *whole-of-community action*, it has been the lack of clear direction in how to do this [12-16] that strikes me as the most disconcerting aspect of our deficits of healthcare equality.[17] There is still a chronic undersupply of health workers in rural and remote areas[2] that perpetuates the health disparity between urban and rural/remote people.[3, 18-20] There is still a lack of knowledge about how to support effective collaboration and co-ordination in the delivery of health and wellbeing services.[15, 17, 21, 22] And with our predominant focus on the development of discipline-specific, technical proficiency in health providers, we struggle to gain skills in the inclusive delivery of culturally and locally relevant services. [17, 23-26]

It was this evidence and a degree of boredom that enticed me out of my very safe, professional comfort zone. I accepted some opportunities presented to me to apply my skills in different ways in different contexts. I was invited to expand my work from rural contexts into remote and Indigenous communities and with organisations I had not known existed. It was my confidence in my specialist (technical) knowledge that made me feel I could legitimately contribute to these new contexts that I knew little about. However, this was still a very passive experience for me, where I was just observing and not connecting in any way to what I was seeing. I still did not really think any of the disadvantage was really my problem.

During one of these ventures outside my usual professional and geographic boundaries, I was struggling with my inability to prove to my managers that I was delivering on my 'core duties' of providing efficient and effective speech pathology services. I asked a new colleague, "This isn't my backyard. Shouldn't I be working in my own community?" He answered bluntly, "It doesn't matter where you put in, as long as you put in." What he did not add at that point, but gradually revealed to me, is that it was not my professional and technical contribution that was important. It was actually what I would learn, and learn from *relationships*, that would be valuable. It was being prepared to understand, share and connect with other people that would make a difference. It was through relationships, that I started to really engage with the injustice and unfairness of disadvantage. It was through meeting and listening to the people whose lived experience was disadvantage, that I could gain some insight. And with this insight, I truly started to know what it meant to 'care.'

The stories I heard from the communities and families, described health inequality in ways that no numbers and data could. Like the mother whose children had to go into care while she took her toddler to the city for a developmental assessment and returned with a bundle of recommendations that *she* would need to implement in the absence of any local specialist support. Like the grandparents who had four of their grandchildren in their care and were struggling to maintain regular school attendance while dealing with a mix of the children's trauma related behavioural challenges and their own age-related health issues. And like the Aboriginal community who were mourning the third youth suicide in as many months.

The stories that come from this type of adversity tell of people's experience with the many and varied traumas in their lives. These stories, or narratives, give an indication of not just individual experience but also what meaning is given to the experience. An experience is not static because what is learnt or understood from a particular experience changes over time. New narratives are formed as the initial experience is reflected upon, spoken about, re-interpreted and influenced by subsequent experiences.[27, 28]

The risk is that narratives of disadvantage, adversity and trauma can become collective trauma narratives. Understanding this risk is of particular relevance to those who are striving to understand how

to build healthy and resilient communities. The importance of positive community narratives to counter the segregating effects of collective trauma was described by Abadian (2006). [29 (pp21-22)]

> *Without remedies for trauma, whole communities lose trust and retreat into a frozen state. Collective posttraumatic narratives emerge out of the resulting sense of alienation, isolation, and disillusionment: "We are all alone in this… We have been abandoned… Nobody outside cares about us… Our suffering does not count to them… They only do things for us when there's something in it for them… Those others only care about themselves." If the prevailing mood, perceptions and evolving posttraumatic narratives are not countered effectively, disenchantment develops into more enduring cynicism and paranoia. Boundaries drawn between "us" and "them" become ever more rigid.*

Coinciding with my explorations of the boundaries of my scope of practice, I was at stage in my career when I was beginning to be accorded 'expert' status in certain areas. I participated in professional association forums, presented at conferences and gave input at local, State and National levels on issues of rural service delivery, undergraduate training and competency based standards. However, at this point I started to realise the limitations of a practical way of knowing. Primarily, I saw at this more influential level of 'being' a health professional, that discussions about practice were frequently dominated by the perspectives of a very few. It struck me that while the direction being set for health professionals was informed by well-intentioned consensus it seemed limited by historical perspectives and made me wonder if the direction was forward.

In contrast to the stories of trauma and disadvantage, my own story has been one of privilege—privilege in my family, my upbringing, my education and in employment. I love my comfort zone; I am not a courageous person; and I do not go seeking crusades. Nevertheless, the effect of me being exposed to narratives of trauma, made me realise that by dwelling in my comfort zone, I would be complicit in maintaining the status quo, perpetuating disadvantage and would remain an 'insignificant' and apathetic person of privilege. Yet, even with a growing sense of the need for more than technical and practical approaches to care, I still had little idea how my experience, gained through privilege, could and should be put to better use.

Things became clearer recently, when I recoiled from a comment made in a meeting by a senior speech pathologist. She was complaining to those in attendance about universities who, she said, "take in too many students and then put the responsibility on us [clinical speech pathologists] to provide them all with placements." I was quite taken aback when she continued, "As we are already overloaded and are refusing the placements, their subsequent reliance on those 'alternative' project placements is just de-skilling the profession." There is no denying that her comments disturbed me considering my work in the last few years has been on developing some of those 'alternative' placements—alternative placements that I consider have values of collaboration, knowledge-sharing and *care* at their core.

Nobody challenged her comments, however, this meeting and other instances like it, [30, 31] elicited in me a growing emotional reaction to the assumptions that underpin health service provision and how we are preparing students to deliver care. I was angry at the acceptance that health clinicians have become too important or busy to teach their future colleagues. I was frustrated by the lack of any critique that there is only one way to 'properly' prepare students. I was saddened by the fact that unchallenged opinions perpetuate sameness in approach, silo people's responsibilities and do not encourage attainment of

collaborative solutions. I was reacting emotionally to what I sensed, but did not yet fully understand, as the *oppression* inherent in ill-applied decisions informed by technical and practical knowledge.

My increasingly passionate reactions and a simultaneous desire to work with people, whose endeavours are informed by reflecting on *why* they do what they do, mobilised me on a journey towards a far more critical appreciation of healthcare and its practice in Australia. Habermas (1971)[9] describes this as an 'emancipatory' lens through which knowledge is processed. Trede, Higgs, Jones & Edwards (2003) explain that *"Emancipation means setting people free from unnecessary, un-reflected, and taken-for-granted assumptions and expectations. Assumptions are no longer hidden but are exposed and questioned. This process of becoming aware of values and assumptions enables people to question their intentions and interest."* [32(p4)]

Through a greater willingness to engage with disadvantage, I was fortunate to discover that there are many people, from many sectors who are striving to rethink and do things differently. These people are reflecting on what it means to prepare health workers who care about more than having the clinical expertise to deal with individual instances of illness or impairment. They recognise that the complex social issues that impact on health and wellbeing require collaborative and integrated actions. They are investing in initiatives that maximise available resources through engagement, collaboration, knowledge sharing, and networking at local levels. It was through these relationships and the ensuing sharing of individual and community narratives, that I came to understand the benefits of allowing my practice to be informed by emancipatory knowledge.

Working with these people laid the foundations for the co-development of the Specialist Integrated Community Engagement—SpICE Model.[1] SpICE is a model that we wrote as we tried to capture and describe what had worked in a collaborative project to expand speech pathology services in rural and remote communities of NSW.[33(p58)] Contained in the model that describes how to enhance community wellbeing, are the key principles of *"build[ing] capacity in all relevant sectors of the community through a Community of Learners; advocating local, inclusive, practical solutions; and embedding sustainable, long-term and dynamic approaches to enable a cultural shift."* [1(p139)]

It was recognised that the addition of students in the application of the SpICE Model would provide a catalyst for communities to focus actions and explore new ways of utilising specialist services (a specialist service is defined here as one that's aim is to 'serve' a community to improve wellbeing). Simultaneously, students could be provided with an opportunity to see and experience for themselves the many and varied reasons why providing care to people is not as simple as just being a good clinician. With these benefits in mind, Charles Sturt University (CSU) was approached by my co-author of the SpICE Model, and the first SpICE working group was subsequently established in 2012.

The working group comprised four workers from Murrumbidgee Local Health District (MLHD), NSW Department of Education and Communities (DEC), CSU and the Wagga Wagga Indigenous Coordination Centre—the former Department of Families, Community Services and Indigenous Affairs (ICC- FaHCSIA). Three of us had a long established collaborative learning relationship through the Riverina Schools Project,[34] and this helped to inform the further evolution and delivery of SpICE. The SpICE group, of which I was the MLHD worker, commenced activities with NSW rural and regional communities, to explore approaches to address child and family wellbeing. Because the SpICE Model had evolved from the delivery of speech pathology projects focussing on child wellbeing,[33, 34] the initial manifestation of SpICE activities maintained this focus with speech pathology students undertaking activities in early childhood education, school and child health settings.

As we set up these first SpICE placements, I had anticipated facing many of the barriers to collaborative and interprofessional learning and endeavour described in the literature. The issues cited relate to territorialism based on suspicion, prejudice, resource limitations, professional standards and organisational culture and lack of a supportive policy context.[17, 24, 31, 35-38] However, this start-up phase for SpICE was relatively smooth and positive despite the many agencies, levels of government and individual identities and cultures involved.

My sense of SpICE's ability to overcome complex barriers was strengthened by this initial experience with building collaborative relationships. Working within what is described in SpICE as the Community of Learners, these relationships were built up by the participants over the course of establishing and implementing SpICE student placements and activities. Relationships with their knowledge exchange, building of trust and learning from collaborative endeavour, are described in much of the literature, as the mechanism for building the social capital that enables people to overcome traditional divides and move forward on complex social issues. [22, 37, 39-41]

We particularly wanted students to learn in this collaborative context so that they might reach an understanding about the importance of connecting with people and the benefits of drawing on their assets as local community members in order to deliver effective health services. Our aim was to establish a collaborative learning placement for the students. In SpICE, the term *collaborative learning* has been adopted instead of *interprofessional learning.* This has been done to be inclusive of the SpICE partners who do not view themselves as having a 'profession' but still have much to offer in terms of teaching and learning. By learning with and about other people with different occupations and life experiences, we believed that both the students and the communities would develop new ways to share 'specialist' knowledge and thereby enhance community wellbeing.[38]

To this end, the SpICE working group sought people who could work with us to support students while they were on a fieldwork placement. In each community, we needed a group of people who had a thorough knowledge of an aspect of wellbeing in their community and were well-placed to teach and mentor students in their learning. There was no requirement that these people, our SpICE Community Mentors, were of the same discipline as the students. Nor did they need prior experience in student supervision. In fact, it was not even necessary that they were in the paid workforce, as long as they had skills and knowledge about wellbeing that was beneficial and worth sharing.

The mentors were identified to the working group in a number of ways. Some were participants in the initial community discussions around SpICE. Others were nominated by a manager or co-worker. Some came into the role unofficially and after the commencement of SpICE activities, to fill a void left by another organisation withdrawing from SpICE. However, most of the mentors had at some point been recommended by a number of community members. These community recommendations indicated that the mentors were generally well recognised, trusted and connected people in their communities.

Referred to collectively in this report as *community mentors*, there were actually two types of mentor. The *learning* mentors were the immediate and day-to-day support people in relation to each organisation that hosted students. They were responsible for orienting the students to the organisation, identifying the learning activities with the students, monitoring progress and supporting the students while they were with a specific organisation. *Debriefing* mentors had a broader role that was not necessarily specific to a host organisation. Their role related to orienting and connecting the students to the community, working with them on their higher-order learning (reflection, understanding context etc.) and guiding students on issues of a sensitive nature. Both types of mentors were members of the

community of learners and as such, had access to the SpICE working group who could provide additional discipline-specific support as needed.

The community mentors provided workplace experiences for students in contexts relevant to rural and remote health practice that extended beyond traditional health settings of hospitals and community health settings. These settings included schools, preschools, supported playgroups, and outreach services to remote and closed Aboriginal communities. These non-traditional contexts exposed students to many of the social determinants of health that are often 'obscured' in traditional specialist practice contexts.

As mentioned in my introduction, I was impressed by the preparedness and ability of the mentors to willingly take on the support of students from occupational backgrounds different to their own. I have posed the converse scenario to my health colleagues. When asked if they would consider supporting students from other disciplines (say teachers), in a health facility, their response has generally been in the negative. Their reasons have predominantly been around not having the time or not seeing the relevance of teachers learning about health practice. This contrast in attitudes highlights for me, that specialist health workers still require a great deal of evidence to convince them of the legitimacy and reciprocal value of collaborative learning.

This study aims to contribute to the evidence base relating to collaborative learning models. To this end, the SpICE Model's ability to build capacity in student fieldwork placements is examined by exploring the experiences of community mentors in the preparation of health workforce students.

METHOD

The preceding section has told my story of how I arrived at the position that has guided this research project. Firstly, I described the influences that have shifted my understanding of healthcare provision towards the 'emancipator' and shaped my critical appreciation of what constitutes legitimate preparation of a future health workforce. Secondly, hearing community stories provided a way of understanding the human impact of inequality but also reinforced the need to generate positive stories to build healthy communities. Thirdly, I have come to understand that complex social inequalities require solutions informed by the knowledge sharing that arises from collaborative relationships and endeavours within a particular context and place.

Influenced by these three factors, I embarked on a narrative inquiry—an exploration of the stories these SpICE mentors live and tell.[27] I considered narrative inquiry an appropriate way of researching collaborative learning in SpICE. Through the shared examination of the experiences and attitudes of the mentors, narrative inquiry could enable the transfer of the uncaptured knowledge[28, 42] of the mentors who appear to have wholeheartedly embraced collaborative learning. Narrative inquiry could also foster partnerships between the communities participating in the research and myself as a researcher. Furthermore, partnerships facilitate the successful uptake of evidence into practice,[22, 43] which could further strengthen the SpICE collaboration.

By the time all required research ethics approval processes had been completed and I could commence my research in earnest, nearly a year had passed since the initial SpICE placements. We had commenced preparation for the second year of SpICE placements and amongst other things, I was very interested to hear from the mentors to find out what impression, if any, SpICE mentoring had made on them.

I sought research participants by emailing the managers of the 27 mentors who participated in the initial placements and requested that they provide the research invitations to their relevant staff (see Appendix 2 and 3). Six mentors consented to participate in this research project (see Appendix 4), all were women employed in educational settings (early childhood educators and primary school teachers). Three of the participants were from a regional NSW community with a population just under 17,000 and the other three were from a rural NSW community with a population of just over 11,000. All but one of the participants had either senior or specialty roles within their organisations and had a number of years of experience in their field. These participants remained in the study throughout with three of them agreeing to further interviews as part of member-checking process.

I started my data collection by interviewing the mentors. The semi-structured interviews (see Appendix 5) took about an hour and were conducted in the participants' workplaces or sometimes by phone. The interviews were interspersed with SpICE placement planning meetings. It was common for me to finish a research interview and then meet with the participant again 15 minutes later for a Community of Learners' meeting. Even though these meetings were predominantly about planning, there was a great deal of evaluation of the previous SpICE placement occurring. The research participants were particularly active in the group conversations, as if the interviews were a preparation for the broader evaluation. As a result, my research journal frequently reflected a mix of thoughts and insights from both the interviews and the meetings.

After the interviews were completed, the next round of SpICE student placements commenced. I found myself in a predicament as I started the first level analysis of the mentor's interviews. I was in a *caring* state. I cared about peoples' wellbeing. I cared that my SpICE students really engaged with learning about care. I cared about specialist services and knowledge being available, in some way, in geographically and culturally disadvantaged contexts. I cared that I was doing something meaningful to re-dress the disadvantage.

However, as with many new things, there are hurdles and uncertainties and SpICE is no exception. This second year of SpICE proved challenging on a number of fronts. There were students from different professional disciplines to be integrated into the placements. We had to negotiate and work around systems and procedures designed for traditional student placements. We had new communities hosting students. The SpICE working group members were all trying to embed SpICE into our respective organisational structures. We were trying to spread the word about SpICE's achievements in a context where there are few extant measures of wellbeing. And we were tired, annoyed and taking out our frustrations on each other.

My predicament was that I now cared but the task of acting on this was becoming very daunting. The temptation to return to my comfort zone was very enticing. I told myself it was "all too hard." I pined for my 'proper' job of fixing communication impairments not the problems of the world. I justified that my family's need was greater than these strangers' needs. I tried not to listen to the burdensome stories of disadvantage. As a distraction, I made myself listen to the mentor's interviews. Remembering a positive tone of the interviews, I sought to immerse myself in what they told of their experiences hoping I could take inspiration from their words. In this way, I embarked on my first level 'analysis' of the interviews while I travelled the rural roads between SpICE communities listening to the recorded voices of the mentors.

Effectively, this approach managed to just sustain me through to the end of this difficult phase. More importantly, the comfort I had felt by immersing myself in the mentors' voices, motivated me to complete the research. However, I had not yet got to a point where I understood what the importance of the research would be. I just had an overwhelming sense of how fortunate it was that there were people like the mentors participating in SpICE.

I started a more thorough analysis after the interviews had been transcribed and read over. I started with a loose thematic analysis, but significantly it remained the tone of the interviews that seemed most prominent. All the interviews had a positive tone that contrasted starkly with both the literature and what I knew of the difficulties of collaborative and interprofessional student mentoring, rural life and accessing specialist services. The transcripts were testament to the fact that I had been aware of this tone during the interviews, as I made many attempts to prompt the participants to tell me more of the actual or potential negatives of their experiences; but to little avail.

I decided that the next step in my analysis was to look at this tone in more detail. By examining the manner in which this tone was conveyed in the interviews, the mentors' use of temporal orientations became apparent. In narrative inquiry the past is used to convey significance, the present conveys value, and the future conveys intention.[44] When I coded their comments according to their references to the future, past and present, I started to see there were three distinct ways they expressed their positive attitude. Firstly they imagined what could be *better* in the future. For example, when explaining how she and the students had different knowledge bases, one mentor said "We *could* work together and help [children] *in the long run*" (Participant 4). Secondly, they described how they *resolved issues* in the here and now. For example, one mentor described supporting the students following a cancelled placement experience saying, "I then *grab* a phone with—I *try* everybody" (Participant 3). Finally, when they reflected on what had been *achieved,* the mentors said things like, "I just *found* it valuable learning—it *enhanced* my learning" (Participant 5), "It *was* great!" (Participant 1).

To test how well this analysis fitted a segment of the data, I checked the temporal analysis on all the interview segments that related to one topic of the interviews—that of caring for children. This not only confirmed that I could understand the information through a temporal lens but it also provided many examples of the phrases and vocabulary the mentors used to convey intent, value and significance. It was from these phrases that three clear attitudes of positivity emerged, those of *hope, care* and *joy*. Hope was expressed with phrases like "we'll keep our eye on the *prize*" (Participant 6) and "to see the *bigger picture*" (Participant 2). Care was conveyed by examples like "It's something that's *dear to our hearts*" (Participant 6) and "It's a *passion* for children" (Participant 2). Joy was evident in comments of "she was *amazing* in her holistic approach" (Participant 6) and "It was *delightful*…" (Participant 2).

As part of the iterative process of narrative inquiry,[45] I returned to some of the mentors to discuss what I thought I had found. The ensuing discussions added further rigour to the study by re-examining the meanings of the attitudes with new insights generated from the mentors' added comments and reactions. These additional field notes helped me in the process of re-storying the interviews into three attitudinal narratives.

While I set out with this study to better understand how these mentors experienced collaborative learning, I did not know at that point what the mentors' stories would eventually make meaningful. The research findings, that is, the narratives of the mentors, are not presented as being representative of how all mentors would make sense of this particular experience. Instead, they are what resonated with

the mentors and I through the process of inquiry.[46] They provide an insight into the value these mentors placed on collaborative learning. Layered with my own experiences of SpICE, these narratives provide another lens with which to qualify the legitimacy of alternative health student placement models like SpICE.

FINDINGS

Below are the stories of the SpICE mentors, re-presented as three attitudinal narratives. The 'stories' depict the phenomena. In this case, the phenomena are the attitudes of *hope, care* and *joy* that the mentors described as they talked about their experiences of collaborative mentoring. Whereas, the 'narratives' are the inquiry into the phenomena[47]—in other words, what resonates in the stories. By merging together the interview transcript segments, comments from subsequent conversations, and field notes, I have used the *mentors'* voices to convey what I understand "to be the essence" [48(p575)] of what they told.

In composing the narratives, I have referred to the work of Labov (1972)[49] regarding narrative structure. Because the stories were gathered in interviews, from multiple participants and with some shared prior knowledge between the participants and I, they vary in structure to what would be found in single-participant, spontaneous stories. As a result, I have made some minor modifications in the re-presented narratives in order to insure that the essential narrative structure was not obscured. For example, to provide necessary background I have had to construct some parts of the abstract and the orientation. I have done this by referring to my field notes and what I already knew of the events through my work. I have also had to group the complicating actions, evaluative clauses and resolutions, in order to present the mentors' multiple descriptions as combined, sequenced exemplars. In all stories the codas appear unaltered from the mentors' original words.

For the sake of narrative flow, the original tense identified in the analysis has been altered in some instances of the stories. Also some turns of phrase have been borrowed from various mentors to give each story a distinct voice. The voices have also been made to flow by removing many of the hesitations, repetitions and unfinished sentences of natural speech. I have chosen to use the word 'Centre' to refer to both the early education and school settings where the mentors worked. Likewise, I refer to teachers and child care workers collectively as 'educators,' and all health workers and health students as 'specialists.' I have not indicated in the narratives the sections that have been altered in the re-storying, as the narratives are as close to verbatim quotes as is possible while still making sense to the reader. Nor have I indicated which mentors quoted individual phrases, as while there were some stronger mentor voices, the similarity of the participants' contributions served to amplify the narrative content.

In summary, the following co-authored narratives contain the voices of all the research participants as together we explored their experiences of being collaborative learning mentors for SpICE. To introduce the narratives I have drawn on the words of Abadian (2006).[29(p22)]

> *"A healthy society has a medicine cabinetful of balanced, optimistic, gratitude-inspiring, and abundance-oriented collective narratives that tell of getting through dark times, the goodness of life on earth and the goodness of people, and how people are deserving of love, abundance and joy. These healing narratives honor the self that was hurt and all others, and offer understanding of trauma as a stage in growth."*

THE MENTORS' STORY OF HOPE: *"We've got to be thinking long-term. It's not just the children now; it's the children of the future as well."*

Well, let me explain why I want the students to see what we try to do. There's a family I'm thinking about as I tell you this. Worthlessness is too strong a word. Maybe it's more tragic? There are a lot of children in the family. Some have attended our Centre but not all of them. One of the youngest children attends here now. Well sometimes he comes and sometimes he doesn't. He has so many health issues. From his diet to cycles of head lice, this child suffers from it all. On top of all that, there are his challenging behaviours. It's a mammoth effort for his mum just to get her child here. It's a good day if they get as far as the car-park. On those good days, we go out and meet them in the car-park. We take her child into the Centre. In greeting them in the car-park, we kind of say, "We acknowledge what you have achieved just in getting here today. We respect the effort you have made to do the best you can for your child. Now we will work with you by doing the best we can for your child."

Not surprisingly, this child has many additional needs. He needs lots of help to learn. He will always need lots of help to learn. But it would just add to his mum's burden for us to say, "You need to take him to a specialist. You need to get a therapy program for him." His mum's already grieving. Anything to do with a child that may be negative is going to cause some kind of grief and loss to a parent, whether it's normal or something they're going to grow out of, or not. It would be so unkind if we told her *we* couldn't do anything until she had seen the specialists. For one, there are very few services available here and then there are long waiting lists for the ones that are here. And for this mum, even though transport isn't a problem, she just wouldn't have the social confidence to front-up with her child at the specialists' clinics.

Anyway, I wouldn't like any Tom, Dick or Harry to tell me what they thought about my child. They need to have some kind of knowledge behind my child and my family. I think knowing the family is really important. I think relationships go a long way before diagnosis and stuff like that. You have to be sensitive to the fact that if you go too fast, parents may not want to do anything about it because they don't feel that you're giving them the right information—the right information for them.

So with this little boy, we've been treading very carefully. We sat on it for a while. We got the opinions of other people, not to meet the child initially, just to talk it over. And we kept talking to his mum. At last we got to the step where we said to his mum, "So you remember that information we gave you…" It took months to get her on board as we had to do it carefully and slowly.

We'll keep our eye on the prize which is this little boy's holistic development. Obviously we have general training in terms of child development and learning but we need the broader view and people with specific knowledge to help us. But that support needs to be accessible to the family. It needs to be provided here in a familiar place so this little one has familiar people around him. By getting the specialists to see him here, they get a more realistic view of his skills, as much as possible, other than going into the home. It is also one less place the mum has to try and get him too.

So that just goes back to why I thought it was great that I could mentor the SpICE students in our setting so they get to know the way that we operate as well. I want them to understand that it's a passion for children and education that's our focus in working together. If we've got a common goal, we're all on the same path. It's okay that everyone's at a different point on that path because we're all learners along that path. My biggest hope is that these experiences will increase the number of specialists who consider coming in to the Centres and working directly with the children—because that also enhances our skills. I want the students to see that working together is really powerful and we value what other people bring to our environment.

And so do the families. This mum didn't work with the specialists because they were the best at what they did. She made the effort to bring her little boy because the specialists connected with the family. They did what they could to make it possible for the family to take part in the therapy. So for this little boy of ours, if we make that effort to work together, we can try to chip away and break that cycle of hardship. It might be slow and we can't change everything instantly – just a bit at a time. But with a little bit of love and care there's some hope that his life will be worthwhile, not just another tragic story of disadvantage.

THE MENTORS' STORY OF CARE: *"It's something dear to our hearts."*

I came to be mentoring the students in a round-a-bout way. Initially our Centre wasn't going to host the SpICE students. Actually, we knew very little about SpICE as we hadn't been part of the planning. But we had been invited to participate in some training the students were presenting at one of the host centres. Anyway, my staff and I arrived for the SpICE session to be told that the SpICE students had gone! The Centre's manager was away and the other staff didn't know about the SpICE program. It was a funny day. First the students had been turned away and then nobody even knew that *we* had been invited to attend. So, we were turned away as well.

I then grabbed a phone—I can't remember who from SpICE called me back, but we ended up speaking with the students and opened our doors to them. We said they were more than welcome to come in and work with our educators. I don't think I could've lived with myself if I hadn't supported the SpICE students to the best of my ability. If I'd left them thinking "Well if this is what it's like in the real world, why would we want to work in the real world? Why would we want to work in this town?" To be turned away I think, for want of a better word, it was a real kick in the guts to them. So, yeah, I kind of sit back and think, "Yeah, I really feel for them."

I really like the concept of SpICE—the basic idea of speech pathology students coming to town—working inside playgroups, daycare, preschool, school and an Aboriginal medical centre environment. When they were sort of abandoned, well, it bothered me. Like this whole aspect of their learning, this education context, might have been lost to them. That chance to see what we do with the children and that sometimes working with the adults, the parents, isn't as easy. All the knowledge that could have been shared between the professions and the rapport! It would have just been—yeah, the loss of that would have been huge. So I just did everything I possibly could.

Look, like I said, I've been a uni student. I remember how I felt on my last day of prac. My uni mentor just hopped in, asked me if I had any questions and I kind of said, "Well it's a bit late now. We're up to day 30 and this is the first time I've seen you." So, I think there's nothing worse than being out on prac in a community and not feeling that anyone cares about you. I think the mentoring role is about supporting the students through the process. It's not about doing the job for them. I know they have to stand on their own two feet sometimes. But they still need to know there is someone there for them. Someone they're a bit familiar with or have some kind of relationship with. So if something goes wrong for the students they know there is someone who's going to help them sort it. It could be like they see things happen in the different workplaces that maybe they don't necessarily agree with. They may feel that they're not being given the opportunity to do what they thought they were there to do. So like, if they're there to work in a classroom and they feel they're stuck in an office the whole time just making resources, or whatever, but they don't get to work with children. Those sorts of things they need to talk through with someone who has the bigger picture.

We have to remember they are still students. Sometimes things go wrong for them and sometimes they might get it wrong. They also need to feel valued for what they contribute. So, we make sure our expectations are really, really clear from the start. We give out our philosophy—that's what we abide by basically. Obviously the whole reason behind it is that is if there is a hiccup, we always say to them, "We focus on the children. Our number one priority is the children." If you've got a foundation then you've got something to come back to. It's important to understand the mistakes and to explain what they've done well. Also, talking about our philosophy gives us the chance to talk things through rather than making assumptions. I guess particularly when you're working with people coming from different disciplines, you know. Like, the speech students might have seen something from a speechie angle that we haven't considered. We might be wrong! That's part of the growth for us all.

So, it's like, technical skills and attitudinal skills—they need to go hand-in-hand. People need to trust their specialist is caring. The students could end up being the best clinician in the world, but if they can't connect with people then there's no point. They really need to understand the huge impact of connecting with people to do their job well. Like, you don't want someone with a negative attitude or being too self-important. It breaks down relationships. But if you don't care about the students and don't support them, then they can't learn how to do it either—learn about caring that is.

THE MENTORS' STORY OF JOY: *"That sense of joy that comes when accomplishments are noticed helps us get up in the morning and go on."*

Yes! Look, it was delightful having contact with the students. It was really positive seeing how they worked together. They were enthusiastic, engaged and respectful of our organisation when we talked about our part of the SpICE project. They were very open and easy to work with. I guess I go back to that philosophy about being life-long learners. And if we're bringing students of different disciplines into our community, it can only be positive for us as well. There's so much for us all to learn!

At the very beginning of the SpICE program, when the girls came in and talked about speech pathology, I went, “oh my goodness, I know a little bit, but I don’t know enough.” It was great! I really, really enjoyed the knowledge and information that they gave me. What comes to mind is, you know, a child that may be able to speak clearly to us but has a little bit of a difficulty and we usually go, “Oh, they’ll be right. By the time they get to school, it’ll be right.” It’s not necessarily so, and I didn’t know that. So that there has changed my perspective. It was great. They have more knowledge of that so it’s good to work with someone that knows something different. I might have more knowledge of child development, but they have more knowledge of something else.

I think anything that works around your ability to communicate with other people in a professional way is a benefit. I think that’s one of the things you come out of university with—a great bank of theoretical knowledge. But that ability to be able to communicate that knowledge to others is really crucial. So if you’re able to take yourself out of your little silo and talk to other professionals and share that knowledge with them in a useful way, in a way that you can see applies to their context, it’s going to be much more beneficial.

The more you experience, the better it makes you as a person and as a professional. And sometimes, even though at the time the experience might not seem so relevant, later on you might find that it actually is. The more opportunities you have to experience different things, the more open it makes you to different changes and experiences too. And I think the fact that the students have the opportunity to come out to different towns and different areas is great—just to be able to see what’s out there.

Having the chance to be a Mentor just added to the experience. I really believe in that idea of being life-long learners and this gave us another chance to increase our capacity and skills. Having this role for people who have got passion and who are wanting to share—it fires them. And for the students, my sense is, having those people with passion, you know, it inspired them. Yeah—watching them grow in their time with us was really rewarding. I think my role was pretty minor but I suppose I was a small part of something that has obviously had a pretty big impact.

I thought it was good that people—that students of other professions that have something to do with children, are being sent to look at what we do because we’re not often seen as a ‘profession’ other than babysitters. Our job is way more than that. We partner with the family and we partner with the child to ensure the child’s best interests. We also have to partner with people to try and bring in support for families when it’s needed. So we are all, yeah, working together. The students helped us notice what we do well and to celebrate it.

And I guess working with them, I guess it’s really brought to the forefront that I like working with people. I used to think I was sort of a loner. Really I’m not. I’m finding I’m rather a social butterfly! To have that experience is just—was excellent for me and for my growth. It made me realise that I’ve got good interpersonal skills. I don’t just have to work with prac students, like educators. I could transfer my skills with other professions entirely. And I found it was valuable learning. It enhanced my learning. It wasn’t just me passing on my skills. It was, for me, it was left field and another whole new learning experience. Yeah, and my sense is, without SpICE, I wouldn’t have gained that because all my

opportunities have just been with educators and prac teachers. That's what showed me I've got transferable skills.

Look all in all it's been a very positive experience for us you know. We get really excited about the opportunities to try new things. We are very aware we live and work in a community with a shortage of specialists. So to be able to be part of something that may build our community capacity, our connections and our skills in particular, you know, that's exciting to be part of that. It's really lovely. It enriches our lives. It's a joy. It helps us with the bigger picture you know. I guess to keep within our mind how all the pieces fit together and again fit together for the children. And again, I come back to that word 'collaboration.' So being part of that bigger picture is very positive.

It's so important to capture that excitement. So it was disappointing—maybe it was because it was the first time, you know—but my sense was, instead of a celebration in that community meeting at the end of that first SpICE, it was kind of a bit of, I don't know if 'negative' is the right word. But it wasn't a celebration of, "look what's been achieved," it was a bit of a yeah, a negative ending. Deflating, that's a good word - probably more deflating for the students. It should've been a celebration of "Look you've been part of this and look what we've achieved!" It's not about *not* acknowledging the negatives because that's how we learn. But focussing on the, you know, *celebrating* the successes. It keeps us excited and empowered when we can share and acknowledge what we've done well. It helps to keep us going and to keep trying new things.

I think it's a really great program. I know that students have had the opportunity to experience the rural setting. And, you know, they all said that it was great to be able to go outside of just working in the specialist clinic essentially—to seeing their work in different contexts and how it can be implemented there. One of the best things has been that one of the SpICE students is now employed here. That was a real benefit—something that has stuck with me as really important from the program. It just really goes to show how it has helped. People are still talking about and using what they made for us. And the fact that this community now has another specialist - It's massive!

DISCUSSION

"Attitudes empower us. They encompass all that we do"

Just as I started writing this report, I had another conversation with one of the mentors. The conversation helped to clarify some of the meanings from the narratives that I would need to discuss in this paper. I had been explaining to her the three attitudinal narratives of *hope, care* and *joy* that I was re-storying from the interviews. When I asked her thoughts she told me, *"These attitudes empower us. They encompass all that we do"* (Participant 6). With that comment I felt confident that this narrative inquiry—the exploration of these stories of experience—was indeed *highlighting* important social realities. As Clandinin and Rosiek (2007) explain, *"Experience…is always more than we can know and represent in a single statement, paragraph, or book. Every representation, therefore, no matter how faithful to that which it tries to depict, involves selective emphasis of our experience."* [27(p39)] Her comment on the all-encompassing and empowering effect of these attitudes was confirmation for me of the importance of sharing these stories.

We went on to discuss her comments about why she had said *"you need to trust your specialist is caring."* She explained, *"When you go to the doctor, you're already feeling sick. You're not at your best and you want to feel better. You need to trust that your doctor cares about you and your situation. You want him to make you feel better not worse. If he has the wrong attitude it makes you feel worse."* Thinking of the shortage of doctors and specialists in rural areas, I asked her, *"If there was only one doctor and he had the wrong attitude, do you just have to put up with what you can get?" "No!"* she replied. *"You have to deal with the attitude."*

Her comment was further evidence for me that students need to learn about these attitudes *before* they start their professional careers. In part, this is to circumvent the need for people like the mentors having to deal with specialists who have not acquired the right attitude. As the mentors have highlighted though, it is primarily because technical skills alone do not facilitate the kind of care that takes into account the complexity of people's lives and issues.

While there is increasing recognition of a broader definition of what constitutes legitimate specialist practise,[17, 34] my experience with student placements, suggests that traditional placements, leave little room for learning much more than technical skills. This is in part due to the fact that student supervisors' accountabilities are measured by the numbers of people seen rather than things like meaningfully engaging with communities or tailoring locally relevant strategies. For example, it is difficult to justify time spent engaging with the parents of a supported playgroup when you have a client waiting list of 6 months or more. I also know in my typical clinical setting, despite my intentions, it is difficult to shift from teaching technical skills when this is what the students expect, what they are assessed on and of course, what I do as a specialist. The mentors' narratives revealed that they are not subject to this same bias towards the technical because they are not of the same profession as the students. This means that they are well placed to provide a learning context that's focus is towards attitudinal learning.

Over the course of our conversation, I asked this mentor more about why we should reveal these attitudes. She replied that it helps people, like herself, to get up in the morning *"to remind us why we do what we do."* My research journal reflects the same sentiment (Journal Entry November 18, 2013), where I note that I desperately wanted to show members of the SpICE working group excerpts from the interviews. For one of my SpICE colleagues I wanted her to *hear how valuable her input had been*. For another it was so that she could have multiple examples of how the SpICE work she does *is benefitting communities*.

While I was not specifically asking her about *hope*, it is this narrative that contains the 'why' and 'intent' aspect of care. The narrative describes the brighter future imagined by the mentors. It tells of how they use this vision to guide how they strive for better education, better specialist services and ultimately, better lives for children. My hope is that student experiences of this narrative will lead them beyond a here-and-now perspective of care. Moreover, if they learn to adopt this attitude of hope, it will give them direction as they deliver their care.

When I was re-constructing the mentors' story of *care*, I was again struck by the positive tone of the information. I reviewed the transcript of my voice memos to confirm that throughout I had noted the mentors spoke of potential problems as *valuable learning experiences.* There was no blame attributed for mistakes. Their comments conveyed a sense of respect for the students as *learners* and for what they contributed to their hosts and the community. The resultant narrative, voices reciprocity: that to learn about care, you need to be shown care when you learn.

This narrative also reminded me of the mantra we worked by when I spent a few years in disability services. We had to apply equally our 'duty of care' and give clients the 'dignity of risk.' This meant respecting an individual's right to make choices for themselves even if there was a known risk involved. I have always found dignity of risk to be a very profound concept, but one that is incredibly hard to deliver in a risk averse culture.[50] My experience of balancing these two mandates was in relation to providing client services. However, the mentors talk about it in relation to student learning and the students' right to risk failure in their pursuit of learning.

The narrative of *care* presented, quite clearly outlines that a duty of care requires the carer to be proactive. Perhaps an oxymoron, but strategies need to be put in place that will support risks in the safest way possible. The mentors spoke of strategies like, starting with clear expectations; establishing supportive relationships; being available; and giving feedback that acknowledges but does not blame the missteps of learning. In effect these strategies create the safe learning environment that facilitates students having a go and trying things for themselves. This nurturing environment is a major factor for providing the type of quality student placements that effect students' intentions to seek work rurally.[51, 52] This revelation certainly reassured me that despite my initial concerns, 'my' students could indeed be well *cared* for by these 'others.'

And finally, I come to the narrative of *joy*. I had a hard lesson to learn about joy before I could really appreciate its meaning in this research. To explain, I have to return to the beginning of my research story where I spoke of 'my' students. I have to admit to a very strong sense of pride in what I contribute to a student's positive learning experience. But with that pride, also comes a strong sense of ownership of the successes.

The problem with this ownership was brought home to me in a discussion with the SpICE working group members, in relation to an ex-SpICE student. This new-gradate had commenced work in a position created as a result of SpICE. Amongst other things, she had sought guidance from us on re-badging her job title to make it more meaningful for her predominantly Aboriginal clientele. The fact that she was already questioning the relevancy of the status quo seemed, to us, a great success.

One of the SpICE working group members said she would "claim that." I indignantly replied that, "I think I have as much right to claim responsibility for that outcome!" Her look of surprise told me that I had clearly misunderstood her. Rephrasing, she said that she meant she would "claim the joy." I realised from my initial reaction that I still had a bit of learning to do about sharing the journey of students and sharing the joy of broader success.

I learnt a lot from the mentors' story of *joy* that has expanded my understanding. What it illuminated for me was an alternative method to conceptualise measuring the effectiveness of care. Like many health workers, I am well versed in demonstrating effective expenditure of the health dollar by collecting productivity statistics and other quantitative outcome measures. However, I have a growing sense of the inadequacy of these measures to capture what is really working in the amorphous arena of rural and remote care and wellbeing.[21, 40] Furthermore, I am frustrated by the difficulty of capturing the evidence of what I know is working at a micro level to gain influential traction at the macro level.[21, 32]

What was offered in the *joy* narrative, was a clear illustration of how the mentors used their sense of joy to help them identify what was significant in the experiences they had had and provided for the students. Their assessment of a positive outcome was not framed in terms of what they could prove to those who need clear and generalisable evidence. Their focus was on the many little positives that interrelate and result in a bigger benefit. Things like individuals sharing specialist knowledge that manifests as increased community knowledge economies; [53] or recognising that you have interpersonal skills that are transferable to many contexts.

Learning to tune in to joy shifts the focus from empirical, quantifiable outcomes to a reflective assessment of the benefits to ourselves and the people our actions affect—the quality of the process rather than the quantity of it. It may be perceived by some as a less effective measurement approach for influencing systemic change. However, its value in providing the type of feedback that is influential at a local and personal level is clear from the narrative. For students who do go on to work in the more isolated contexts of rural and remote practice, this approach is particularly valuable as it helps to develop a self-reliance to ameliorate the effects of isolation. Importantly, it connects a practitioner to the place and people they serve rather than to the system they serve within. It nourishes and perpetuates the sense of community that is so highly valued by the inhabitants of smaller rural and remote communities.

In summary, revealing attitudes of *hope, care* and *joy* is of obvious value in the preparation of students for the emancipatory practice that delivers care. These positive attitudes do not ignore the complex contexts of disadvantage in which they were generated. Rather, they embody the care giving 'medicine cabinet' that is necessary for resilient communities that promote child and family wellbeing.

CONCLUSION

> *"How do we distinguish whether the general direction of a narrative…is healthy-giving or posttraumatic? A first test is exquisitely simple: How does it make you feel to rehearse this narrative in your mind? Does this narrative enhance your joy or deepen your fear?" Abadian (2006).*[29(p25)]

As I finish writing this report I am reflecting on the journey this research has taken me. While I set out, I thought, to discover more about SpICE's mechanisms for building student placement capacity, I have in

fact, learnt more about what it might take to reduce inequality and disadvantage. Being a relative newcomer to the social justice arena, I felt uncertain about my ability to give voice to the plight of those who face injustice and inequality. However, the stories in this research have convinced me to act more bravely in adopting an emancipatory stance.

The positive attitudes of the mentors in their narratives show a way forward on redressing inequality that does not ignore the complexity of the issues facing rural and remote Australians. Nor, do they shirk from the responsibility that people of (perhaps relative) privilege have in participating in striving for beneficial change for others. The existence of these narratives also reinforces that SpICE's community of learners creates the nurturing and safe environment that many people, not only students, can draw from to give them the courage and confidence to pursue new understandings of care. By sharing their narratives, the mentors have set the scene for ongoing critical review of assumptions that potentially limit the development of a truly *caring* specialist workforce.

Another lesson I have drawn from the narratives is that student placement *capacity* should not be defined by the quantity of students undertaking fieldwork experience, but by the breadth and quality of the experience offered. There is no doubt that SpICE through its use of community mentors delivers this breadth and the quality learning that comes from collaborative learning and endeavour. Far from 'de-skilling' our specialist professions by relying on 'alternative' placements, SpICE is building capacity in meaningful and responsive ways.

While I still consider these SpICE students 'my' students, I have come to realise that it is not a concern about the validity of collaborative learning that made me anxious about sharing the students initially. Rather, it is a sorrow that in handing them to others a part of my journey with them is over. Like any parent who wants the best for their child, I have to embrace the idea that no matter how well I have prepared them, if they are to fully learn about *care,* 'my' students have to learn with and from others.

I am still nervous about what I might unleash with my call to action and discussion from this research. However, I take comfort in these narratives that give me joy. And I take courage from a poem by Leunig: *"Let it go, Let it out, Let it all unravel, Let it free and it will be, A path on which to travel."*

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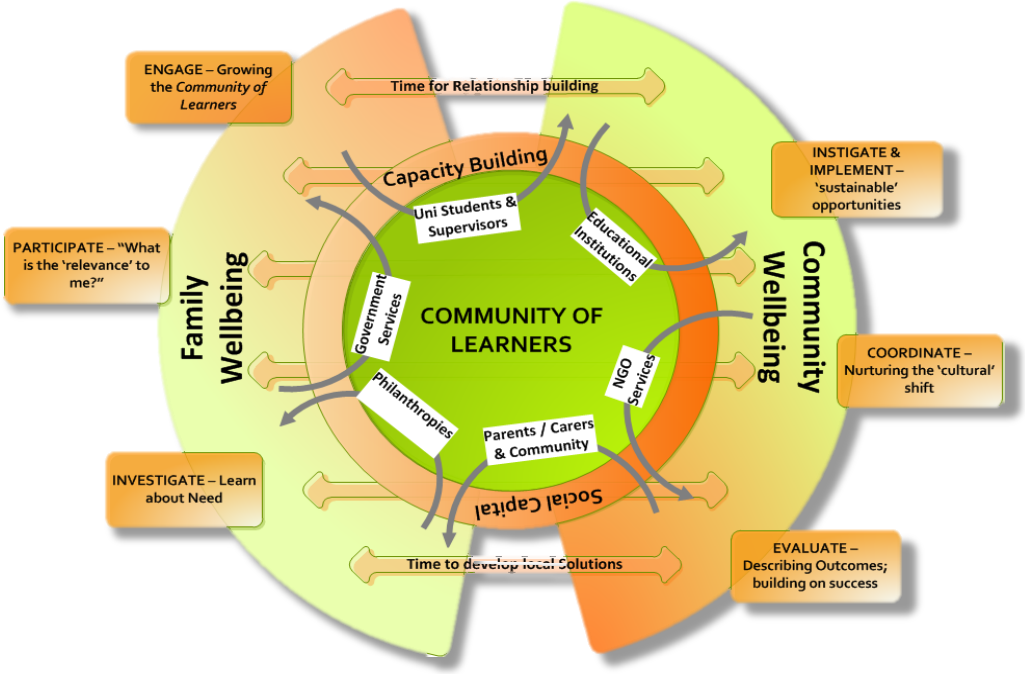
APPENDICES

APPENDIX 1 - THE SPICE MODEL

The SpICE Model, as pictured below, illustrates how to enhance family and community wellbeing, and is built upon the notion of building capacity and social capital in a community, by genuinely engaging all key stakeholders, fostering cross-sector initiatives and embedding sustainable approaches while a 'Community of Learners' evolves. The Community of Learners refers to the concept of all stakeholders involved in a program, project or service (including service recipients) being learners as well as imparters of knowledge and service expertise. It is not a defined group of representatives, rather a description of the 'champions' who make the 'cultural shift' that embeds sustainable change to address family and community wellbeing.

SpICE Model Specialist Integrated Community Engagement



APPENDIX 2 - INFORMED CONSENT.

MANAGER INFORMATION SHEET

STUDENT MENTORING USING THE SPICE MODEL – A NARRATIVE ANALYSIS OF COMMUNITY MENTORS.

Dear Sir/Madam,

In October and November 2012 your organisation participated in the roll-out of the Specialist Integrated Community Engagement (SpICE) Project. Staff from your organisation were involved in this project as Learning Mentors or Debriefing Mentors (referred to as 'Community Mentors' in this document). In this role they supervised and supported the speech pathology students on placement with your organisation.

A study of the experiences of these Community Mentors is being undertaken as part of the Rural Research Capacity Building Program sponsored by the Health Education and Training Institute (HETI). Participants in this research project are now being sought.

Attached is a Participant Information Sheet which outlines details of the research project. Could you please forward this Participant Information Sheet to your relevant staff (i.e., those who were Learning or Debriefing Mentors) for their consideration.

If your staff decide to express an interest in participating they can contact the Principal Investigator, Marijke Denton, by mail or email to the address provided.

Your support in providing appropriate protocols for working with your organisation is also sought (e.g., seeking permission from Aboriginal elders or advisors or Senior Management). Please feel free to contact me if you have any questions.

Please notify me by return email of your action regarding this request.

Thank you for your time in considering this invitation.

Marijke Denton
Principal Investigator
Murrumbidgee Local Health District

APPENDIX 3 – PARTICIPANT INFORMATION SHEET

PARTICIPANT INFORMATION SHEET

STUDENT MENTORING USING THE SPICE MODEL – A NARRATIVE ANALYSIS OF COMMUNITY MENTORS.

Invitation

You are invited to participate in a research study into your experience as a Community Mentor when you mentored speech pathology students in 2012 using the Specialist Integrated Community Engagement (SpICE) Model. Your information is valuable in helping us understand your perspective, both positive and negative, on using inter-professional mentors as part of health student workforce development.

The study is being conducted by Marijke Denton, Senior Speech Pathologist (Student Educator) at Albury Community Health Centre (Murrumbidgee Local Health District) as part of the Health Education and Training Institute's (HETI) Rural Research Capacity Building Program.

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

1. What is the purpose of this study?

The purpose is to investigate the experience of Community Mentors (Learning Mentors and Debriefing Mentors) who undertook supervision and support of speech pathology students in 2012 as part of the SpICE Project. By capturing the experiences of Community Mentors we will have a better understanding of what factors and attitudes influence community involvement and collaboration in undergraduate student supervision and education. This information will help inform communities, health services and universities in the development of appropriate strategies for training the future rural health workforce.

2. Why have I been invited to participate in this study?

You are invited to participate in this study because you were a Community Mentor (either as a Learning Mentor or Debriefing Mentor) during the initial roll-out of the SpICE Project in October and November 2012. The information you provide about positive and negative experiences are valuable in helping us understand this role.

3. What does this study involve?

If you are considering involvement in this study, firstly, you will need to express your interest to Marijke Denton. If you agree to become a participant you will need to sign the attached Consent Form.

You will then be asked to participate in a face to face interview with the Principal Investigator to describe your experiences of being a Community Mentor. This interview will take up to an hour and will be arranged at a time and place convenient to you. You will be asked questions about your previous experience, activities and reflections in relation to supervising students.

You can request a copy of your interview transcript and this will be available within two months of your interview.

You may be asked to participate in follow-up interviews at a later date (within four months of the initial interview). The purpose of follow-up interviews is to clarify any gaps in information from the original interview, and to discuss themes emerging from the research. This collaborative approach to discussing the themes is part of the research design in order to continue to develop relationships between participants in the SpICE Project (including the Principal Investigator).

4. Are there risks to me in taking part in this study?

The interview and subsequent consultation are of low risk. The interview asks for you to share your 'story' about your experience of being a Community Mentor. This information will be treated in a respectful and confidential manner and you will have opportunity to request the exclusion of information prior to publication of the final report.

5. Will I benefit from the study?

This study aims to further knowledge and understanding of the issues in preparation of rural health workers. It may improve the experience of future Community Mentors. It will provide you with an opportunity to reflect on and share your personal experience, however it may not directly benefit you.

6. How is this study being paid for?

The study is being sponsored by HETI as part of its rural Research Capacity Building Program. Support is also being provided by the Murrumbidgee Local Health District, the Western NSW Local Health District and the Southern NSW Local Health District. The Principal Investigator is an employee of the Murrumbidgee Local Health District and was employed part-time by Charles Sturt University during the SpICE Project implementation. The Principal Investigator has no supervisory or line management responsibilities to participants in this study.

7. Will taking part in this study cost me anything, and will I be paid?

Participation in this study will not cost you anything, nor will you be paid. However, you will be reimbursed for your personal time and reasonable travel expenses to the amount of $70 (through use of vouchers e.g., for petrol) if participation needs to occur in your own time.

8. What if I don't want to take part in this study?

Participation in this study is voluntary. It is completely up to you whether or not you participate. If you decide not to participate, it will not affect your relationship with the agencies involved in the research (i.e., the Murrumbidgee and Western NSW Local Health Districts) or with the Principal Investigator nor will it have any bearing on you work role or future participation as a Community Mentor.

9. What if I participate and want to withdraw later?

New information about the subject being studied may become evident during the course of the study. You will be kept informed of any significant new findings that may affect your willingness to continue in the study.

If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason. You can also request that any information you have provided be withdrawn from the study.

10. How will my confidentiality be protected?

Any identifiable information that is collected about you in connection with this study will be de-identified. Only the researcher named above will have access to your identifying details and these will be held securely at the researcher's residence. Your identifying information will remain confidential and will be disclosed only with your permission, or except as required by law. In reporting results of the research, information you provide will be disguised to maintain your anonymity. You will have opportunity to review information provided during interviews and you can request exclusion of information you have provided in part or whole.

11. What happens with the results?

We plan to disseminate the results in a research report that is provided to HETI and supporting Health Districts. The study results may be presented at a conference or in a scientific publication, but information will be provided in such a way that you cannot be identified. Results of the study will be provided to you, if you wish.

12. What should I do if I want to discuss this study further before I decide?

When you have read this information, and if you decide to express and interest in participating, you can contact the Principal Investigator, Marijke Denton, by mail or email to the address provided.

Marijke Denton will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact her on 02 60581813.

13. Who should I contact if I have concerns about the conduct of this study?

The ethical aspects of the project have been approved by the Greater Western Human Research Ethics Committee (HREC) of the Western NSW & Far West Local Health Districts. If you have any concerns or complaints please contact: The Executive Officer, Greater Western Human Research Ethics Committee, Western NSW Local Health District , PO Box 143 Bathurst NSW 2795 or telephone (02) 6339 5601.

Thank you for taking the time to consider this study.

If you wish to take part in it, please contact:

Marijke Denton

C/- Albury Community Health Centre

PO Box 503

Albury, 2640.

OR

Marijke.denton@gsahs.health.nsw.gov.au

This information sheet is for you to keep.

PARTICIPANT CONSENT FORM

STUDENT MENTORING USING THE SPICE MODEL – A NARRATIVE ANALYSIS OF COMMUNITY MENTORS.

I have read the attached Participant Information Form on the above named research study, and understand the purpose and procedures described within it.

I have been made aware of any known or expected inconvenience or risk and of their implications as far as they are currently known by the researchers.

I agree to the audio-recording of any interviews conducted as part of this research.

I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this study and understand that I can withdraw at any time.

I understand that I will be given a signed copy of this document to keep.

Participant's name (please print): ……

Signature: …….. Date: ……

APPENDIX 5 - SEMI-STRUCTURED INTERVIEW PROMPT SHEET.

Explaining why I'm conducting the interview.

This interview is to gather information for a research project on the experiences of Community Mentors who participated in the SpICE Project in 2012. Your responses will be analysed with the other participants' responses to determine themes about what the experience was like. The final report will help us understand the experience to help us plan for future activities in relation to rural student placements.
Are there any questions you'd like to ask before we start?

Can I record the interview? I will also be taking notes.

Prompt Questions

1. How did you become a Community Mentor as a Learning Mentor or Debriefing Mentor for the SpICE Project?
2. Did you have any experience with mentoring university students prior to the SpICE Project? Tell me a bit about this.
3. What did you think being a Community Mentor meant before you started the role? Did this definition change as a result of being a Community Mentor?
4. Describe the context in which you worked while you were being a Community Mentor.
5. What did you do as a Community Mentor?
6. Can you tell me about a particular experience as a Community Mentor that has stuck with you? Why was this memorable?
7. In your opinion what was easy and difficult about being a Community Mentor?
8. Has the experience changed anything in your work or everyday life?
9. What do you now think is the relationship between 'community mentoring' and 'student learning'?
10. Is there anything else you would like to tell me about the experience?

Final

Summary of key points. Thanks for participating. Answer any other questions.