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Preface

The Australian Journal of University-Community Engagement is a refereed journal published twice a year by the Australian Universities Community Engagement Alliance, a not for profit organisation dedicated to enhancing the engagement capabilities of staff and universities by developing expertise, fostering collaboration and building their communities across Australia.

The AUCEA E-Journal strives to be inclusive in scope, addressing topics and issues of significance to scholars and practitioners concerned with diverse aspects of university-community engagement.

The AUCEA E-Journal aims to publish literature on both research and practice that employ a variety of methods and approaches, address theoretical and philosophical issues pertinent to university-community engagement and finally, provide case studies and reflections about university-community engagement.

The Journal aims to stimulate a critical approach to research and practice in the field and will, at times, devote issues to engaging with particular themes.

All manuscripts will be subject to double-blind peer review by three (3) professionals with expertise in the core area. The three (3) reviewers will include at least one (1) editorial board member.

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Editorial Comment

It is our pleasure to make available this spring edition of the AUCEA e-journal. The edition draws on the 2011 AUCEA national conference whereby those providing refereed abstracts were invited to submit their full papers for consideration for the journal. The edition has five papers, one case study and four research papers.

The paper by Hudson and Hudson provides key insights on understanding distributed leadership and professional learning communities. They present a cyclic model for facilitating professional leadership communities through using a distributed leadership model. Butcher, Leathley and Johnston present an evidence based awareness action framework for universities, communities and organisations to use when examining how they can engage with people and communities who experience disadvantage to provide ease of access for these groups to these stakeholder interests.

Walters, Stagg, Conradie, Halsey, Campbell, D'Amore and Greenhill are the first in a series of papers on health issues. They

describe community engagement activities by two rural clinical schools using a stakeholder analysis that involved students, university views and others. Woodroffe, Spencer and Auckland describe a process of community engaged health research when describing the Community Health Needs Assessment (CHNA) process and applying this to a case study of the Tasmanian University Departments of Rural Health partnership with five Tasmanian communities and stakeholders. Finally, Mahoney provides a case study of a community engagement process in a new urban community medical education program.

The papers in this volume have been carefully selected, and provide not only evidential basis for the topics that are researched but also valuable insights that will be of use to those in the field. We hope you enjoy reading this edition.

Donella Caspersz

Lead Editor



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Distributed Leadership and Professional Learning Communities

Peter Hudson & Sue Hudson: Queensland University of Technology

Abstract

This paper focuses on understanding distributed leadership and professional learning communities (PLCs). Through an Australian Government grant, the Teacher Education Done Differently (TEDD) project, data were analysed from 25 school executives about distributed leadership as a potential for influencing educational change through forums such as PLCs. Findings will be discussed in relation to: (1) Understanding the nature of a PLC, (2) Leadership within PLCs, (3) Advancing PLCs, and (4) PLCs as forums for capacity building a profession. A cyclic model for facilitating PLCs is presented, where information such as issues and problems are brought to the collective, discussed and

analysed openly to provide further feedback. There are implications for leaders to up-skill staff on distributed leadership practices and further research required to determine which practices facilitate successful PLCs.

Keywords: Leadership; Professional learning; Distributed leadership; Learning communities

Introduction

Reviews into education reform (e.g., House of Representatives Standing Committee on Educational and Vocational Training [HRSCEVT], 2007; Masters, 2009) show that changes in teaching practices are not adequately implemented. For instance, Masters (2009) outlines “inadequacies in the extent and quality of current teacher professional development” (p. 49) while the Top of the Class Report (HRSCEVT, 2007) indicates,

“Notwithstanding its importance, and the number of recommendations that have been made in past reports about the need to improve practicum, problems continue” (p. xxv). Many of the solutions rest with practitioners as enactors of education reform; yet universities, as educators of future practitioners, need to play key roles in supporting their development. Building capacity within organisations requires effective leadership to present ways for advancing its goals. This study focuses on a specific university-community engagement that explores concepts around leadership and professional learning communities (PLCs) within schools as a possible cost-effective solution for enacting reform measures. In the context of education, the following discusses leadership practices and professional learning through PLCs.

There are many leadership models and ways to frame leadership. Trait leadership (Yolk, 2002), contingency, charismatic,

and servant leadership (e.g., Burns, 1978), and analysing leadership behaviours (Leithwood & Jantzi, 2006; Sergiovanni, 1995) are considered ways to understand leadership. Other educators have presented models such as the full range leadership model by Avolio and Bass (2002); however these models (e.g., Avolio & Bass) can be criticised for not portraying effective leadership practices. For instance, Avolio and Bass include laissez-faire practices with strategies such as abdicating responsibility as part of their “full range leadership model”. Nevertheless, transformational leadership offers practices that contribute to the values, vision and ethics of an organisation (Kelloway, Barling, Kelly, Comtois, & Gatlen, 2003). Inspirational leaders use transformational practices to motivate others (Avolio & Bass, 2002), and the distribute leadership with a focus on shared visions for achieving organisational goals (Galbraith, 2004). Distributed leadership pools the available expertise for achieving desired

outcomes, with a benefits-for-all approach that is transparent to everyone in the organisation (Gronn, 2002). It is shown that distributed leadership is contextual and varies according to the needs and practicalities of the organisation (Spillane, Halverson, & Diamond, 2001).

Professional learning communities (PLCs) are considered valuable forums for developing knowledge towards solving problems (Easton, 2008). Similar to transformational leadership, building a learning community requires establishing goals for team learning, sharing a vision within a system approach (Senge, 1990). PLCs facilitate organisational learning at macro and micro levels for considering “more effective ways of doing things” (Roberts & Pruitt, 2003, p. 3). A PLC is a group of people wanting change within a focused area of need. A key outcome from PLCs in schools is enhanced student learning as a result of uncovering effective teaching practices (Harris & Jones, 2010). Collaborative

deployment of resources and knowledge within a “climate of trust and respect from colleagues” (Stoll, 2010, p. 155) provides the supportive conditions for establishing and maintaining a PLC (Clarke, 2009). Importantly, PLCs aim to achieve “long-term cultural change in an organization” (Stoll, 2010, p. 157) by embedding an interdependent group cohesion for facilitating professional growth (Cooper, 2009). Although this paper focuses on PLCs and leadership within school contexts, synergies will be highlighted that apply to contexts in other workplaces. The context for this paper, however, involves leadership roles used for establishing, facilitating and advancing PLCs with purposeful and practical applications.

Context for Establishing and Facilitating a PLC in this Study

A three-day Mentoring for Effective Teaching (MET) program was organised and promoted as a professional learning

community (PLC) where each member's opinions, experiences, knowledge and skills about mentoring and leadership were recognised as valuable for group learning. Each member actively participated within a range of topics, for example: (1) mentoring and the mentor-mentee relationship, (2) school culture and infrastructure, (3) Hudson's mentoring model (i.e., personal attributes, system requirements, pedagogical knowledge, modelling, and feedback; Hudson, 2010), (4) problem solving and leadership, and (5) action research for enhancing mentoring and leadership practices. The activities associated with each topic were designed to be interactive and utilised various teaching strategies to maximise participant thinking and discussions. For instance, the teaching strategy "think, pair, share" was used for the question: "What may help facilitate a positive mentor-mentee relationship?" Participants were also placed in random groups for different activities to maximise networking and sharing of ideas. The

sharing of knowledge and skills was intended to develop common understandings between participants.

There were 25 school executives (mainly site coordinators who manage school programs) involved in this three-day professional development program facilitated by the authors. There were 23 females and 2 males with 18 of them aged between 30-49 years and 5 older than 50 years of age. Only 2 were between 22-29 years of age. Their roles within the school varied with 15 who were either principals or deputy principals, 3 were heads of departments, and 7 had other specialised roles in the school. The majority of the participants had significant experience of working in education systems (i.e., five for 6-10 years and 19 for more than ten years), with only one participant having less than six years experience. It was noted that 15 of these participants had worked in their current schools between 1-5 years, 2 for 6-10 years, and 8 had worked in the current school for 10 years. These participants

were taken through the MET program and were expected to facilitate this program in their own schools.

Data Collection Methods and Analysis

This case study aimed to investigate 25 school executives' understandings of professional learning communities (PLCs) and leadership in order to understand how to advance PLCs towards successful outcomes. Data were collected over a three-day period where all participants were involved in the MET professional development program. Data collection also involved emails and interviews from selected participants who had implemented the Mentoring for Effective Teaching (MET) program in schools after facilitating this particular program themselves. This assisted in collecting data about how PLCs could be advanced.

This qualitative research used audio recorders for whole group discussions on topics and issues involving PLCs and also

within smaller groups (i.e., 4-6 participants) at various points during the three-day program. Recorded dialogues were transcribed by an experienced research assistant. In addition, the executives engaged with various intellectual materials that were used to facilitate discussions. Within a social constructivist paradigm (see Vygotsky, 1978), each small group shared their responses which were audio recorded and they also recorded personal responses on paper. All material was transcribed and collated within the discussion topics (i.e., understanding the nature of a PLC, leadership within PLCs, advancing PLCs, and PLCs as forums for capacity building a profession).

Finally, three questionnaires requiring extended written responses were administered, one on each day of the program. Some key questions on the three surveys included: What do you think is a professional learning community (PLC)? How might a PLC have a role or influence in the improvement process for

teaching and learning at your school? How can preservice teachers (undergraduates) be part of a PLC? What leadership skills are required for initiating and maintaining a PLC? In order to analyse data, written responses were collated under common themes (aforementioned discussion topics), with excerpts taken from participant responses as examples that were considered representative of the theme (Hittleman & Simon, 2006). It was important to provide open response questions that would allow participants to express freely their ideas about leadership and professional learning communities.

Findings and Discussion

Drawing upon the multiple data sources indicated in the methodology, findings will be discussed in relation to the literature and under the following themes: (1) Understanding the nature of a PLC, (2) Leadership within PLCs, and (3) Advancing PLCs.

Understanding the nature of a PLC

These executives were asked to define a PLC for which responses were very similar and could be collated into a general theme about being co-learners within a professional group, which was articulated clearly by Participant 1: “Any group of like-minded, or like-educated people who interact with a common purpose or goal”. Harris and Jones (2010) and Stoll (2010) outline the need for an agreed understanding of how a particular PLC would operate to ensure commonly-shared goals. It was indicated by various participants that this like-mindedness could be specific or general in nature but required a purposeful direction. Participant 9 stated that PLCs are, “a group of people who have an interest and willingness to share knowledge, expertise, experience and practical tips on similar topics”. Collaborating with groups of people (or the collective) was given high preference for developing knowledge and skills in an organisation by these participants. For

example, Participant 16 noted PLCs as “professionals with shared vision, but also the bringing together of their collective skills”, which is highlighted by other educators (e.g., Huffman, Hipp, Pankake, & Moller, 2001) as underlying principles of PLCs. It has been long recognised (Clarke, 2009; Senge, 1990) that sharing a leadership vision and pooling collective knowledge and skills can create a climate for high functionality within a PLC. Importantly, collective knowledge can translate into improved professional work practices (Stoll, 2010).

There was a strong affirmation from the participants that a PLC was for the common good that sought higher purposes for exploring, refining, and embedding practices to advance an organisation’s goals. There was also the notion of a PLC as a safe environment where people can actively voice opinions and ideas that may lead towards enacting more effective practices within their positions. To illustrate, Participant 2 stated a PLC was “a

melting pot of constructive ideas and discussions which are involving people in a variety of roles within education” while Participant 16 claimed it as a “professional sharing (particularly in regards to progressive/innovative and non-traditional methods) with the goal of educational progress” (parenthesis included). This communal sharing towards progress is not unlike the early Greek forums where Plato and Aristotle would deliberate with colleagues over philosophical endeavours to address societal issues and problems, and indeed for the “common good”. In this study, the participants were school executives within a profession that focuses on educating children. This requires personalised interactions where teachers work together for a common purpose in a socially-constructed learning environment. Participant 23 noted those within a PLC as stakeholders who are “committed to maximizing learning potential from each other”. Without commitment and purpose, a PLC would rapidly dissipate; thus

everyone within the PLC needs to understand the advantages of being committed to such forums.

Many ideas were brought forward from the participants about the nature of a PLC. One participant in particular highlighted an “information-discussion-feedback cycle” as a framework for the discourse within a PLC. Participant 24 stated this framework can support a professional learning “...community where discussion and feedback from all levels... can come together to address needs and develop ways to bring about effective change”. It was discussed within one focus group that information in the form of professional knowledge is brought to a PLC to aid its agenda. Such information generally presents for discussion and deliberation on actions to advance the PLC’s goals but requires input from “all levels” to create change effectively. Furthermore, it was outlined that all stakeholders need to benefit from a PLC experience “where

everyone learns each other’s knowledge, skills and experiences” (Participant 25).

Executives were asked to give an example of a PLC in their own work environments for which all provided at least one example. Many focused on their meetings within the system structure, such as year level meetings, parents and citizen meetings, reference group meetings, and executive meetings. This highlighted the essential nature of the relationships at varying levels to advance the system’s goals. Participants showed that any one school had multiple opportunities for discourse around specific PLC areas. To illustrate, Participant 5 explained, “We have teams that meet about different issues, for example, Curriculum Reference Group and Juncture Meetings at year levels where we value expertise in our school and share it”, and Participant 12 wrote that her work place has “committees related to KLAs [Key Learning Areas] behaviour support, ICTs [information

communication technologies], and beginning teachers”. The titles of these PLCs presented identities and emphasised a primary purpose of valuing the expertise of those within the collective.

Leadership within PLCs

Organisations require effective leadership and, in particular, inspirational leadership within PLCs was highlighted by these executives. Inspirational leadership includes efficient organisation skills with priorities, personal attributes such as enthusiasm, positive attitudes, and a genuine care for others. These ideas were summarised by Participant 4’s collection of phrases: “Passion for education, great interpersonal skills, effective listener, creative problem solver, does everything for the benefit of the children” and Participant 2 also said, “Providing support and positive feedback to staff in addition to constructive criticism where appropriate. Allowing staff to feel listened to and

appreciated”. A PLC can provide information, discuss and give feedback with affirmative decisions for trialling an innovation. These decisions result from persuasive arguments but, at some stages, an effective leader will need “to have hard conversations and make hard decisions” (Participant 9). Such decisions need to reflect a fairness where the consultative approach has taken place and there is “consistency of judgment and decisions and follow through” (Participant 10). Participants’ comments emphasised that PLCs must have leadership, a person or people who can facilitate the group’s direction, to make the hard decisions, yet provide support where required.

Apart from personal attributes of enthusiasm, diplomatic honesty and “passion for the profession”, leaders of PLCs must present a “practice of mutual respect” (Participant 23) and demonstrate “excellent knowledge and understanding (and) problem solving” (Participant 14). Interpersonal leadership traits

can aid in building and sustaining a PLC (Harris & Jones, 2010). Participant 15 stated that effective leaders aim “to work as part of a team - knowledge is power - leadership is actions not position”. Conversely, a laissez-faire leadership approach was indicated as “ineffectual”, a “waste of space”, and a “stopper for progression”. Leadership behaviour can be modelled and as such these initiators and facilitators of PLCs bring to the table “a vision and willingness/openness to ensure a shared or collaborative process” (Participant 16). It was noted that once a leadership vision is projected then it needed to have a collaborative sharing for such a vision to be enacted. Yet, effective PLCs demonstrate in practical terms they are “equitable – give the team ownership and instil a culture of collective responsibility” (Participant 18). Again, empowering others and distributing leadership can assist to sustain a PLC, with a leader who can “step out of the way, and lead from the back” (Stevens, 2007, p.108). Such leadership may call

upon transformational practices (Geijsel, Sleegers, Leithwood, & Jantzi, 2003) or distributed leadership practices (Spillane et al., 2001) that help the continuation of a PLC. This idea of distributing leadership was a theme in many responses, especially concepts of leaders using their personal attributes to engage others within workplace opportunities, as exemplified by the following two participants in one of the focus groups:

Willingness to listen; their totally human qualities not just the ‘corporate line’. A strong belief in the potential of others around them and the willingness to give opportunities to other staff members – not just the big noters and noise makers of the group. Their belief in me. (Participant 24)

Clear articulation of personal vision and values; ability to persuade and motivate others so the vision becomes shared (collaborative ownership) - consistency and the ability to make tough decisions. Giving authentic feedback and providing opportunities for others to develop their own capabilities; delegating responsibility for outcomes and encouraging ownership. (Participant 20)

Even though PLCs were noted as a positive problem-solving endeavour in this study (also see Stevens, 2007), such communities of discourse need to be aware of each member's level of contribution and that others are encouraged to have equal opportunities in the discussion. Effective leadership would monitor participants' levels of engagement and employ measures to facilitate greater equity of contribution. Participants commented on "empowering others in their roles" to take responsibility for enacting innovations and facilitating collaboration. This empowerment can be noted as distributing leadership. As stated by Harris and Jones (2010), "Distributed leadership provides the infrastructure that holds the community together, as it is the collective work of educators, at multiple levels who are leading innovative work that creates and sustains successful professional learning communities" (pp.173-174).

In this study, collaborative ownership, building capacity and recognising the potential in others presented as leadership opportunities for empowerment of the collective. In the context of teaching, teachers need opportunities to challenge themselves to reach their potential as prospective leaders for which PLCs can provide such a framework (Nielsen & Triggs, 2007). Even though these leaders may need to be "two steps ahead" (Participant 19), problems can arise within PLCs and so PLC leaders must have "great conflict resolution skills" (Participant 17) if a particular PLC is to continue along a positive and productive path. At this point in the Mentoring for Effective Teaching (MET) program, participants were developing a common understanding about PLCs and leadership, as they shared and agreed upon behaviours that characterised effective leadership.

Advancing PLCs

Effective leadership roles appear pivotal for establishing, facilitating, and advancing PLCs with purposeful endeavours (Clarke, 2009; Stevens, 2007). Leaders in such roles lead by example and provide inspiration to others for advancing organisational practices. For example, Participant 11 stated, “Currently, at my school, my principal inspires me to constantly strive to enhance my teaching practices. She is inspirational, as her leadership and diverse practices lead me to believe more in my own abilities as a teacher”. It seemed that personal leadership qualities were essential for advancing PLCs in a positive and open manner, particularly “Being fair and respectful to all staff, supportive to staff, able to listen and be unbiased, has both a working relationship and a social relationship with staff, available to provide support and leadership” (Participant 12). Effective leaders who initiate PLCs consider all staff within the workplace

environment and target individuals and groups of like-minded people for learning within their fields and positions. In the school context, Participant 13 claimed within one focus group that an effective leader has:

The ability to build capacity in the whole school, teacher aides, teachers and admin staff. Their understanding of communication skills – importance of valuing and listening, non-judgemental of the small issues, guide with the big issues.

There appears to be iterative processes for advancing PLC’s goals. For instance, information-discussion-feedback (previously stated by one participant) can present as a framework for operating within a PLC. However, various participants outlined how feedback suggestions need to be tested and evaluated. Figure 1 represents a cyclic model for innovation in PLCs, where information such as issues and problems are brought to the collective, discussed and analysed openly to understand the

contexts, and then feedback is elicited for action. Importantly, this “feedback for action” must be trialled to determine if the suggested solutions are practical and achievable. In this cyclic model (Figure 1), the outcomes of the trialled practices as an innovation are presented back to the PLC to outline what is working and what is not working. This action inquiry allows practices to be trialled with reflections-on-practice brought to the PLC as an assessment of the proposed innovation (e.g., see Harris & Jones, 2010; Kaplan, 2008). Professional learning necessitates trialling an innovative practice to “validate their own curriculum choices and how these choices impact their own teaching and student learning” (Kaplan, 2008, p. 341). Evidence must be gathered in the trialling stage to provide back to the PLC members for further discussion and suggestions in order to advance the practices.

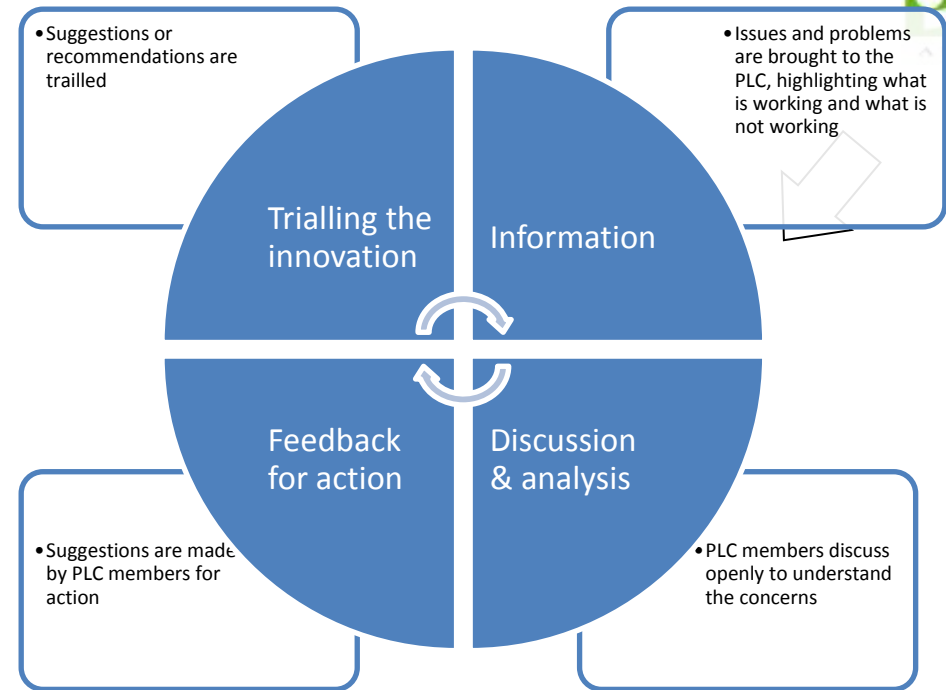


Figure 1. Model for Actioning Innovation in PLCs

PLCs were noted as a way to build capacity within a profession. In this study, all participants discussed mentoring as another way to advance PLCs for building an organisation’s capacity. Participant 4 wrote: “It is a crucial factor in their development. I need to challenge my teachers to be effective

mentors and build the capacity of our future teaching workforce – not just have them for 4 weeks and say well done”. In education, teachers need to work outside of their isolation for which a PLC can present opportunities for collaboration to discuss teaching practices, observing others, and modifying methods accordingly (Clarke, 2009). Individual trialling of proposed actions suggested by PLC members can lead to solutions; however partnering professionals in mentoring arrangements can also provide the support required for implementation. There was little doubt in this study that participants advocated effective leadership as a change agent (e.g., see Boseman, 2008; Fullan, 2008) with mentoring as another way to build capacity.

Conclusion

This study investigated school executives’ understandings of leadership and professional learning communities and how these can be used to advance workplace practices. This study

outlined the nature of PLCs as a collaboration within a professional group where participants become co-learners in philosophical deliberation for addressing and advancing workplace practices. It was discussed that successful PLCs are established with commitment to contextual needs and circumstances that generally aim to achieve practical applications for the common good. It was also shown that the continuation of a PLC requires: (1) effective leadership that is both inspirational and motivational, and (2) an information-discussion-feedback-trialling cycle that utilises specific discourses for problem solving within the workplace. However, more research is required to understand commonalities of effective practice for operating successful PLCs that advance the organisation’s goals.

It was found that a strong relationship existed between successful PLCs and leadership. In this study, the leader’s role was considered pivotal within a PLC as both an inspiration and for

ensuring like-minded people are co-learners within respectful and equitable arrangements. Effective leaders within PLCs were noted to have enthusiasm with problem-solving abilities and vision and, importantly, a way to instil collective ownership and contributions. Effective leaders provide a forum conducive to open discussion and as a productive pathway for building capacity within the workplace environment. Effective leaders guide through decision-making processes, particularly at times when hard decisions are required for achieving successful outcomes aligned with the core business of the organisation. A laissez-faire approach to leadership was considered as a barrier and ineffectual for advancing PLCs, which requires proactive and visionary leadership. The implications for organisations include the development of programs that develop favourable distributed leadership practices for facilitating a PLC. Leaders want to advance their organisations and focus on the core business, which is

embedded within the organisational visions and goals.

Advancing an organisation can occur by identifying issues and discussing these within PLCs where possible solutions can be presented. Importantly, key staff members need to be up-skilled on distributed leadership practices, particularly how practices can be used to facilitate PLCs for successful outcomes.

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An awareness and action framework for transformative community engagement

Jude Butcher, Colleen Leathley and Kristin Johnston: Institute for Advancing Community Engagement, Australian Catholic University

Abstract:

Social inclusion and equity are ever present challenges for community organisations, whether they be universities, schools, welfare organisations or health services. Important questions for these institutions are how can they best engage with people and communities who experience disadvantage and so provide ease of access and a genuine welcome to them? What factors facilitate or constrain how these institutions engage with and provide appropriate support for the people? University-community engagement which includes schools, welfare organisations or

health services has contributed significantly to addressing such questions of equity and social inclusion.

This paper presents a new research-based awareness-action framework for universities, communities and organisations to use when examining how they could engage as well as to what extent they are engaging with individual people, families and communities. The paper presents the educational research from which the framework was developed, together with examples of uni-dimensional low awareness - low action approaches and multi-dimensional high awareness - high action approaches to engaging with communities.

Key words: Transformation, partnerships, community engagement, framework

Introduction

The benefits of social inclusion and participation at individual and community levels are well recognised. Maslow (1968) identified a sense of social belonging as one of the more basic human needs, recognising that it was difficult to develop higher-level needs of self-fulfilment without it. Positive parent and peer relationships have been shown to have an important impact upon social and emotional development (Cripps & Zyromski, 2009). Supportive relationships amongst peers, families, teachers and the broader community have also been shown to be helpful in mobilising social and cultural resources to support academic development (Moll, 2010).

Nationally, the costs of social disadvantage are high, to individuals, communities and the country as a whole. Recognising, and seeking to respond to this, the Commonwealth Government recently released 'A stronger, fairer Australia' (Commonwealth of

Australia, 2009), outlining a vision where all Australians have the opportunity and support they need to participate fully in the nation's economic and community life, develop their own potential and be treated with dignity and respect. The document promotes a mixture of self-responsibility, partnerships and long-term solutions.

For educational, social and community agencies, as a microcosm of the broader society, there are clear benefits, and imperatives, for engaging with their communities and encouraging active participation. The changing social, economic, political and demographic context in recent decades has reinforced the value and necessity of building a strong and cohesive sense of community, with internal and external partners, to ensure all members of society have the opportunity and resources to participate to their full capability. A social inclusion vision for educational and social agencies could therefore extend to ensuring

that staff, students and affiliated partners “have the capabilities, opportunities, responsibilities and resources to learn, work, connect with others and have a say” (Commonwealth of Australia, 2009, p.2).

This social inclusion agenda aligns well with a ‘common good’ or ‘public good’ philosophy on which many faith-based and values-based universities are founded. Providing both a solid platform and a vision, it issues a challenge to all universities to make a difference not only through their learning and teaching, research and community engagement, but also through their contributions to and critique of public discourse and public policy. Importantly, it requires them to address the diversity and complexity of people’s lives and contexts with dignity, and to work collaboratively with partners in the broader community. In doing so it promotes equity, inclusion and active participation.

The public emphasis on this agenda is very timely in the light of the inequities within Australian society. Stilwell reports:

In a wealthy nation like Australia...particular social groups, such as single-parent families, recent migrants from non-English speaking countries, and the long-term unemployed, commonly experience unacceptable levels of poverty. Many Aboriginal communities have living standards more typical of poor people in ‘third world nations’ (2006, p. 8).

There are encouraging signs that societies and universities are actively seeking to foster inclusion and equity through policy and practice. Many universities, such as the Australian Catholic University, have established ‘community engagement institutes’ or equivalent, or developed programs for marginalised groups (Howard, Butcher & Egan, 2010). AUCEA itself, and its Australasian Journal of University-Community Engagement, are founded on the vision of further developing communities, and shaping our future

citizens by working together – within and outside the higher education sector. Individually and collectively, these initiatives highlight a need and commitment to reducing or ameliorating the effects of disadvantage, at individual and societal levels through a focus on mutual transformation which brings benefits to all concerned.

A framework for social inclusion and community engagement

The call, and benefits, for educational, health and welfare organisations to adopt an integrated, community-based approach are clear. Less clear, however, is how they are, or should be, responding to this call, and how they can effectively measure or demonstrate their commitment and efforts to doing so.

Some themes are emerging regarding successful approaches to social inclusion and community engagement. It is recognised that one-off or one-sided initiatives and efforts that are

transactional rather than transformational in nature are likely to have limited effect (Butcher, Bezzina & Moran, 2011) and may even foster real, if unintentional, elements of dependency, paternalism and resentment (Butcher, Johnston & Leathley, 2011). It is also clear that achieving a genuine and sustainable sense of inclusion and equity requires initiatives and efforts that are genuine, system-wide and sustainable (Butcher, Johnston & Leathley, 2011).

Bronfenbrenner's (2005) bioecological model of human development is very relevant to system-wide approaches to community engagement and social inclusion. Humans live and develop within complex and inter-relational social systems, which need to be considered when developing, implementing and evaluating public policies and programs. A broad and holistic definition of a 'community' is required, to encompass not only those formally aligned with an organisation, such as staff and

students and clients, but also the people and elements in the broader social contexts. Furthermore, one needs to consider the different needs, experiences, abilities and aspirations of community members and realise that what works for one group of people, or in one set of circumstances or time period, may not be automatically transferable.

Butcher, Johnston and Leathley (2011) have shown the importance of a transformative, ecologically sensitive and holistic or system wide approach to developing and implementing effective community engagement approaches. The research also showed the need for the development of an awareness-action framework to profile dimensions and perspectives relating to participants' awareness and response strategies in a structured way. The framework provided community-based agencies and systems with a tool for:

- examining how well they engage with their community members; and
- developing strategies to move towards more transformative and more integrated engagement with people who are disadvantaged or socially isolated.

This paper outlines the research from which the framework emerged, the framework's essential elements and its potential application by educational, social and community agencies wishing to progress or monitor the effectiveness of their social inclusion and community engagement initiatives.

Research Overview

The research was undertaken in a metropolitan Catholic diocese, which encompasses some of the wealthier and poorer Local Government Areas in New South Wales. The purpose of the

research was to document how the schools and the system itself deal with poverty including strategies they are implementing for engagement with the poor in the schools. Recommendations for future policy and practice were also to be developed from the research.

All systemic schools in the diocese were invited to participate in the review by survey or written response. In addition, a cross section of six schools was selected, in collaboration with the diocesan executive, to provide a more indepth review of survey, interview and focus group findings. A total of 25 out of 36 Systemic schools participated in the review, of which 20 (80%) were Primary and 5 (20%) Secondary. The number of students in the schools ranged from less than 200 to over 1000. A summary of the key data sources and methods for each is provided below.

Surveys:

Written surveys were distributed via the diocesan office, with a stamp addressed envelope to the researchers. A total of 175 completed surveys were returned from the following groups of individuals:

Table 1
Survey responses by participant group

Participant group	No. responses
Principals	25
Teachers > 10 years experience	58
Teachers < 10 years experience	34
Parents	30
Senior School Support Officers	17
Clergy	5
CEO Leadership Team	3
Welfare agencies	3
Total:	175

The surveys contained identical questions, seeking participants' views on:

- their understanding of 'the poor' when applied to members of the school community;
- role(s) Catholic schools should play in caring for the poor;

- factors helping Catholic schools in caring for the poor;
- factors hindering Catholic schools in caring for the poor;
- recommendations or suggestions to help Catholic schools assist the poor; and
- three ways a commitment to people who are poor should influence the life of the school.

They also provided scope to provide additional comments.

The survey for school principals encompassed the above items, and also sought additional information on:

- the number of students enrolled in the school;
- percentage of students in the school they considered poor;
- policies and strategies in place to assist the poor; and
- possible exclusion of poor from enrolling or continuing in the school.

Interviews:

In addition to the surveys, 29 individual face-to-face, semi-structured interviews were conducted, with a cross section of participants from six schools. These schools were selected in collaboration with the Diocese's Catholic Education Office, to reflect a mixture of geography, size, socio-economic status and perceived sense of community. The interviews were conducted by one of two researchers and provided an opportunity to gain a more detailed and personalised understanding of key issues addressed in the survey.

Focus groups and workshops:

Four focus groups and one workshop were also conducted, which provided an opportunity for the researchers to gain a fuller understanding of the issues, opportunities and challenges of responding to the poor, as per the aims of the Review. These ranged in duration from one hour (students and parents) to one

morning (religious education coordinators, and welfare staff). With the exception of the welfare staff, all focus groups and workshops were conducted by the researchers.

Analysis:

Data from the surveys, interviews and focus groups were reviewed by the research team to identify common themes. These were then collated into a summary publication and presented to diocesan executive staff and a reference group comprising diocesan clergy, staff and parents, which shared and confirmed the findings. The framework was also introduced at this time, and deemed by the different stakeholders to be both appropriate and useful.

Key Findings

All participants in the Review were able to provide a definition of ‘the poor’, and saw their school or broader community as having a key role in caring for them. The depth of responses, however, depicted varying levels of awareness or contact with the poor. For parents and teachers with less than ten years’ experience, in particular, the responses tended to reflect a largely conceptual or academic response, as opposed to a personal or experience-based understanding. Responses from principals, teachers with more than ten years’ experience and welfare agencies tended on the whole to exhibit a more discerning and grounded emphasis and experience, suggesting they “engaged” with the poor on a regular basis and were fluent in their language.

Key insights in relation to progressing an equity and inclusion agenda included:

- The need for an agency to consider multiple dimensions, including material and non-material, in identifying and engaging with those in need in its communities. ‘The poor’ is a complex, rather than simple, construct.
- Agencies need to consider how they can best respond in a way that is appropriate to their unique context, adapting and working effectively within their environment and constructing and applying learning.
- To have a full understanding and appreciation of the poor requires personal encounter – it is not something that can be learned second hand but needs to come from engaging directly with people who are disadvantaged, or socially isolated. This transformative approach must extend beyond a transactional ‘doing’ or ‘giving’. It requires relationships and an engagement, of ‘working with’ the poor where both the giver and receiver are open to being transformed by the other

as part of a collective, caring community. Ultimately, it calls for a conversion of heart and mind.

- Community engagement principles foster a collaborative spirit of mutual transformation and allow for partnerships and relationships to be strengthened and to contribute to the greater good of society. Educational agencies form part of multiple systems, and need to consider the role they can best play, through engaging for mutual benefits, with the broader educational and social systems and networks in their environment.

Awareness-Action Framework

In reviewing the responses and emerging themes from the study, two main dimensions stood out in terms of a participant’s response for identifying and engaging with the poor:

- Awareness - knowing who and where are those in need, and those in need being aware of the support and services available to them; and
- Action - factors that help or hinder; strategies and recommendations for improving care.

Participants' responses varied in terms of the exhibited level of complexity, engagement and ownership for each of these dimensions. Some responses or experiences tended to be uni-dimensional and simple in nature, suggesting limited appreciation or exposure to the relevant issue or people. In contrast, some responses exhibited a multidimensional understanding or approach, indicating the participant had not only personal exposure and engagement with people who are poor, and familiarity with the issue in question, but also a level of efficacy in working within it. They also tended to emphasise sustainable,

community based approaches and a sense of ownership, more than one-off, procedural or transactional initiatives.

This contrast can be seen in the following survey extracts, regarding 'what do you understand 'the poor' to mean when applied to members of our school community?':

Uni-dimensional responses:

1. Those less fortunate than others. Families experiencing financial hardship. (SSSO, JC)
2. Those families who are having difficulty supporting themselves with the income they have available. I imagine these families would struggle to pay school fees and the other day to day costs associated with sending a child to school, for example school fund raisers, school photos, uniforms, etc. (Parent, JC).

Multidimensional responses:

3. 'The poor' are those members of the school community whose income is at a level where meeting the general financial

obligations of school life is a great hardship. This includes uniforms, equipment, fees and excursions. They may also be financially illiterate – unable to prioritise spending appropriately. Families who suddenly find themselves losing income through death or loss of unemployment may also experience great financial difficulty and require emotional assistance during this time as well. (Teacher >10yrs, QF)

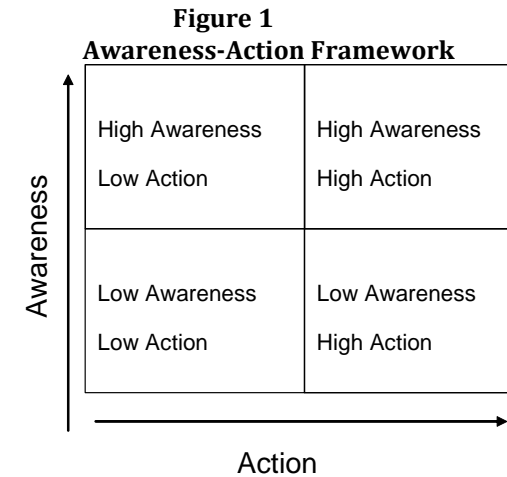
4. The poor within the community can be defined as those who struggle financially but also those who are spiritually poor. Generally, those who are struggling financially are those who pay what they can in terms of fees and school costs but also those who give in other ways, eg their time, food, preparation, volunteer assistance. These people are humble yet happy of heart. Those who are spiritually poor are those who are seeking something more in their lives and yet may be at a loss to name or act on it. (Principal, LD)

It was also evident that the comments could be rated low-high on the awareness and action dimensions, depending on the level of complexity, understanding and familiarity their responses demonstrated. Within the awareness dimension, for example:

- a ‘low’ level would demonstrate limited (uni-dimensional) knowledge or personal experience, and a situation where those in need in the school or community went largely unrecognised. Understanding would be largely conceptual versus personal in nature.
- a ‘high’ level would demonstrate a more personal and multi-dimensional knowingness of people and their circumstances, where people in need are recognised in a compassionate, discreet and sensitive manner. Understanding would be largely empirical and personal in nature, demonstrating a high level of familiarity and efficacy.

- Similarly, within the action dimension:
- a ‘low’ level would be one where the response is limited (uni-dimensional), or largely transactional in nature. This would include referral to another support agency, anonymous donations or no response at all.
- a ‘high’ level would be one which is personal, multidimensional and interactive, allowing for mutual transformation and delivered with dignity and compassion.

Given the identified rating schedule and the recognised interplay between the two dimensions, the following awareness-action matrix or framework was developed.



In ‘mapping’ responses to the matrix, those displaying what could be considered acumen and skill in knowing and responding to the needy in their community would sit at the higher (right hand corner) end of the matrix. In contrast, responses demonstrating a lower level of familiarity or experience, or being uni-dimensional or isolated in nature, would sit at the ‘lower’ end of the spectrum. An example of how sample quotes map to the framework is provided in the following table:

Table 2
Action-Awareness Framework: Low-High Levels

<p>High Awareness; Low Action</p> <p>Example quote: The word 'poor' brings to mind 'disadvantaged', 'need', 'lacking'. As with any community our school community is unique – affected by demographics, multiculturalism, economics, language and social issues – all members of our school community at some point in time would be 'poor' in these areas" (SSSO, XD).</p>	<p>In-between:</p> <p>“There are many dimensions to the notion of 'poor' including spiritual and emotional poverty. Poverty implies a deprivation of something, so people can be poor if they are deprived of services, opportunities or access to reasonable standards of living. In regard to school communities in our diocese, I believe that these non-material types of poverty have been well identified and targeted to date. They are still problematic but they are, at least, in the general consciousness. The real issue is that of material poverty. Those with little or no money, often fuelled by unemployment and other social issues related to poor education, language, immigration, family breakdown, substance abuse, lack of social support, etc. There are many people with little or no money or assets who</p>	<p>High Awareness; High Action</p> <p>Example quote: “The poor within the community can be defined as those who struggle financially but also those who are spiritually poor. Generally, those who are struggling financially are those who pay what they can in terms of fees and school costs but also those who give in other ways, eg their time, food, preparation, volunteer assistance. These people are humble yet happy of heart. Those who are spiritually poor are those who are seeking something more in their lives and yet may be at a loss to name or act on it. (Principal, LD).</p>
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<p>Low Awareness; Low Action</p> <p>Example quote: “Don't support helping those who claim to be poor but don't help themselves or are after handouts – hard to distinguish these though.” (Parent, XC).</p>	<p>need direct intervention and assistance from our school community.” (Welfare, #4)</p>	<p>Low Awareness; High Action</p> <p>Example quote: Ability of school to care for its 'poor' has a strong relationship with how it can connect to its community. Need to look outside traditional school structure to provide greater innovation and access to school resources (Parent, YE)</p>
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Application of the framework

The framework, which was developed from the analysis and organisation of the research data, provides a useful tool for assisting educational and other community organisations to consider where they currently sit on the framework and how they might enhance their awareness and action levels. It could also assist in alerting agencies to particular implications or 'risks' of operating from a particular cell (such as low awareness-low

action) and potential gains and strategies for the educational community in moving towards a higher awareness or action level.

For universities, for example, it could involve reflecting on the policies, practices and attitudes relating to faculty, students and community partners. This would require an honest assessment of how well all voices are heard, listened to or incorporated into university life. It would involve looking not just at how well particular individuals or sub-sets of the university are being served, but whether there are some participants in the university community in need or feeling socially excluded who are not being identified, invited or engaged.

Since its development the framework has been employed in a variety of settings, including an educational department review in Fiji, a tribal discussion with chiefs in East Timor regarding health capacity building, and a housing project in Western Sydney. In these various settings, the framework has proven a valuable and

relevant tool for stimulating dialogue and assessing, with honesty and compassion, where an organisation currently sits along the awareness-action continuum, where it would like to sit, and strategies for moving there.

The tool has both structure and flexibility to identify and assess relevant measures and criteria for 'high' and 'low' dimensions, much as a marking rubric. This could be applied to the awareness and action dimensions alone, or could also encompass sub-dimensions, such as complexity (recognition of single or multiple dimensions); integration (whether strategies are predominantly isolated or linked); attitude (respect and dignity or judgemental); effectiveness (do the strategies seem to be working); and process (transformational versus transactional).

It is perceived that one of the key benefits of the framework is in providing a structure and opportunity for honest and healthy dialogue by organisations (including departments or systems), in

looking at the ways they facilitate inclusion, equity and community engagement in practice. Through reflection on the types of words being used, such as 'helping' as opposed to 'facilitating', the framework can also help identify underlying attitudes and assist groups in moving towards using a more transformative than transactional lexicon and approach.

The use of the framework involves individuals, departments, agencies and organisations devising and answering key questions, preferably determined and reviewed with an external facilitator. Sample questions include:

Awareness questions:

- How do or can we identify those who are in real need in our community;
- How well do we know the members of our community, individually and collectively;

- Would current or potential members of our community feel comfortable approaching the leaders or administrators for help;
- What strategies do we have, or can put in place, to identify those in our community who are struggling and require assistance from us;
- Do we put more effort into attracting members than to meeting their ongoing needs;
- Do we have an understanding and appreciation of the broader context in which our members, and we, operate;
- Are we proactive in our approach, or rely on others to come forward; and
- How can we incorporate a greater level of awareness and appreciation of inclusion and equity through our teaching and learning, fieldwork, research and community engagement work?

Action questions

- When we become aware of those in our community needing assistance, do we respond in a timely and sensitive manner;
- Is this something we do often and comfortably;
- Are our actions done with respect and dignity;
- Whose needs do our strategies really serve;
- Are we willing to be changed by the encounter;
- Is our action essentially transactional and obligatory, or personal and transformational in nature;
- How do or can we work effectively in partnership with our internal and external communities to enhance the lives of our members;
- What opportunities for engagement and participation are we (not) providing;
- How do we ensure the different voices are included, heard and respected;

- What resources do we have, or could put, in place to respond more effectively; and
- How can we enhance inclusion and equity through our teaching and learning, fieldwork, research and community engagement work?

Considerations

The tool is embryonic in nature and further application is needed to demonstrate more clearly its benefits, applications and limitations.

The tool is designed to be adapted to local contexts, and to provide a framework for dialogue and review, rather than rigid evaluation. In this respect, some factors to consider are that:

- If a particular sentiment is not expressed, particularly in a written submission, it cannot be assumed that it does not exist.

- Articulating a sentiment does not mean it is in place, or that it is considered effective by those it is designed to serve.
- Effective facilitation is essential in encouraging and enabling participants to share their ideas and views fully and freely, to ensure all voices are heard and that the 'assessment' and proposed directions are owned and truly representative of the broader organisation.
- The process of moving towards a 'higher' cell requires consideration and sensitivity. Rushing or imposing strategies could have adverse and unintended consequences that do not advance inclusion and mutual transformation.
- To help reduce rater bias, relevant criteria should be determined before self-assessing (perhaps using or adapting the items and questions listed above) and by approaching the task with humility and honesty. An external facilitator should also be considered.

- As dialogue is a key part of the process, the emphasis should be on implementing the framework in a transformative rather than transactional manner. Multiple conversations with different people and over different time frames will assist in this respect.

Conclusion

The awareness-action framework was developed from community engagement based research within an education system committed to developing policies and practices for making schools more socially inclusive. The research showed the need for a school's and the system's community engagement to be multi-dimensional in scope based upon a detailed awareness of a person's and a community's contexts. Such community engagement is aligned with Bronfenbrenner's bio-ecological model of development (2005) and provides a sound basis for

transformational partnerships within and beyond the community (Butcher, Bezzina & Moran, 2011).

For educational, social and community agencies, as a microcosm of the broader society, there are clear benefits, and imperatives, for engaging with their community and encouraging active participation as part of a social inclusion and equity agenda. The research underpinning this paper highlights clear benefits to universities and the broader community when a relational, integrated and transformational approach to promoting equity and inclusion is promoted.

The research also highlighted the value of moving away from an organisation-centric focus, to one of partnership, mutual respect and collaboration; or from uni-dimensional, transactional-based actions, to reciprocal, multidimensional and transformative ones. In essence, it calls for a 'walking with', rather than a simple

'handing out'; of hearing and respecting the voices of all, not just a few.

In adopting such an approach, an organisation needs to be aware of how well it identifies and engages with the needs of its members, particularly those experiencing or vulnerable to disadvantage or exclusion. In addition, it needs to consider how well it engages with its partners in the broader community to meet the needs of its members more fully. Having done this, there is a need to consider the effectiveness of current strategies, and potential opportunities and risks that warrant further consideration.

The awareness-action framework introduced in this paper is offered as a new tool for organisations and agencies wishing to assess, and improve, the nature and level of their community engagement, social inclusion and equity in an honest, reciprocal and transformative manner.



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Community Engagement by two Australian Rural Clinical Schools

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Abstract

To date Australian rural clinical schools have been required to engage with the rural communities in which they are based through a Community Advisory Board. In June 2011, the Commonwealth Government expectations for community engagement broadened. This paper seeks to describe the community engagement activities by two rural clinical schools.

This cross-sectional study sought stakeholder, student and University views of community engagement as part of a larger study of rural clinical impact. Focus groups and semi-structured interviews were recorded, transcribed and analysed for themes.

Major community engagement themes elicited from the data included: personal relationships; individual formal connections; collective structured engagement; strategic regional partnerships; and policy level engagement. The overarching principles also emerged from the data: interconnectedness, and leadership.

By engaging in individual informal and formal relationships, students are drawn in and bonded to their rural communities with reciprocal benefits to both parties. Collective structured engagement provides opportunities for University promotion, and acknowledgement of contributions bonding community members

and partners to rural clinical schools. Strategic organisational engagement and policy level community engagement provides bridging opportunities to build regional capacity and influence policy.

This study provides a model of community engagement by Universities in rural Australia

Introduction

Australian rural clinical schools (RCSs) are funded by the Commonwealth Department of Health and Ageing to provide 25% of medical students with 50% of their clinical training in rural areas (usually 12-18 months) with the intention of contributing to rural medical workforce recruitment. Until June 2011 community engagement expectations of rural clinical schools specified the need for Community Advisory Board (CAB) meetings to build collaborative and strategic relationships, and ensure that existing and planned resources provided maximum benefits to students

and the local community. With program renewal, has come, recognition of community engagement at a broader level to ensure reciprocity between RCSs and local communities. This is outlined in Parameter 5 of the Commonwealth contract (Table 1).

Table 1: New Commonwealth Department of Health and Aging Rural Clinical School Parameter regarding Community Engagement (June 2011)

Parameter 5 – Community engagement and collaboration

Rural health workforce initiatives are likely to be less effective if developed in isolation from the community they are meant to serve. To be most effective, a local health workforce should be developed in response to local health, economic, social, demographic and environmental factors. Doing so requires a university's close and consistent interaction with the local and regional community.

The University will engage with the local community and stakeholders at rural clinical training sites to build partnerships, develop and maintain appropriate advisory structures, and consider community feedback, to ensure the successful delivery of the Program.

The University will develop and maintain structures for community engagement which reflect a willingness to satisfy the needs of both the RCS and the community, particularly in relation to positive rural experiences for students. The Terms of Reference and membership of these structures must reflect support for medical education and training within the community.

The University will work collaboratively with the community, state/territory health bodies, non-Government organisations, other educational institutions and professional groups to maximise the use of local facilities and expertise to maximise the benefit of the RCS for students and for people in the region.

Community engagement of an organisation is characterized by a shared and long-term commitment with a diverse group defined as a single collective. The aim of this engagement is to seek to define and achieve common goals. It has been recognised internationally as an important process for local sustainability of national education and health service program delivery.(Lavernack and Wallerstein 2001; Howard, Gervasoni et al. 2007) As the expectations for community engagement by rural clinical schools broadens, it is important to describe the current engagement to develop a strategic framework for further consolidation of activities.

Flinders University Rural Clinical School (FURCS), Monash University East Gippsland Regional Clinical School (MUEGRCS)

provide longitudinal integrated student placements, where medical students are based in a single rural community for a full academic year, and meet their curriculum requirements by following patients and doctors from general practice into the hospital and community.(Worley, Silagy et al. 2000) Students experience stronger continuity of patient care and continuity of supervision in comparison to their tertiary hospital based colleagues.(Hirsh, Ogur et al. 2007; Walters, D et al. 2011) Mildura Regional Clinical School (MRCS) provide students with more traditional block rotations in the local hospital.

In Flinders University and Monash University RCS sites placements are managed by a local team of academic clinicians and administrative staff who coordinate clinical opportunities and manage logistics to relocate, accommodate, and educate students as well as working to support their integration into the local community. In 2010, these RCS undertook an external evaluation.

As part of this study, opinions were sought regarding how these RCS engaged with communities in their geographically defined locations. This paper focusses on rural community engagement at both Universities.

Methods

A cross-sectional study design was used to seek views from a wide range of broad community members including: CAB and Community Liaison Committee members; community contacts; as well as University staff and health professionals.

More than 50 people contributed to eight focus groups and 16 interviews during the study (Table 2). Participants included: University leadership (coded as Unilead); academics and administrative staff (coded as Staff); GPs and specialists who teach in the programs (coded as Clin); administration personnel from the local health services, local council, government and community

representatives (coded as Partners); and community members (coded as Com). Two focus groups with students were also conducted (coded as Stud). Participants were also coded by their gender (coded M or F) to differentiate the participant voices.

Participants who were unable to attend the focus groups but were willing to contribute to the study were interviewed individually either in person or by telephone. Semi-structured questions included enquiries about the interviewees' present involvement in the local RCS program and their experience of community engagement. Questions were informed by the results of a previous evaluation of FURCS conducted by Professor Couper.(Couper, Worley et al. 2011) Interviews and focus group discussions were recorded and transcribed verbatim. Extensive field notes were taken by the independent evaluators [HC, JH].

A four stage process was used to analyse the focus group and interview data. Firstly, the two independent evaluators [HC,

JH], who facilitated the focus group and interviews in the two RCS independently analysed these data using a grounded theory approach to define the major themes.(Strauss and Corbin 1998) These themes were then refined through an iterative process involving the whole research team. Following this, two members of the research team [LW, PS] returned to the de-identified transcripts and field notes to ensure saturation of themes, tabulate example quotes, and confirm context sensitivity. The final model was presented to a Regional Advisory Group in one location to gain community representative views of the model; and feedback was incorporated into the final model.

Results

Participants described five levels of community connections including: personal relationships, individual formal connections, collective structured engagement, strategic regional partnerships,

and policy level engagement. Two additional key themes pulled these levels together. They were interconnectedness, and leadership.

Table 2: Study participants

	Invited	Participated	Participant group included:
University leadership (coded as Uni Lead)	7	7	Deans: 1 Monash, 1 Flinders. Heads Medical Education: 1 Monash, 1 Flinders. Head School of Rural Health: 1 Monash; 1 Head Gippsland Medical School; 1 Head Gippsland Medical School Medical Education
Rural Clinical School staff (coded as Staff)	18	11	Academic leads: Director FURCS, Clinical Coordinator Mildura, Director Gippsland Clinical School, Academic Coordinator FURCS Academics: 1 Mildura, 3 East Gippsland, 3 FURCS
	17	17	Administrative staff including: Office staff: 2 Mildura, 1 Hills-Mallee Fleurieu, 3 Riverland, 1 Greater Green Triangle Student support/program officers: 3 Mildura, 1 Barossa, 2 Riverland, 2 Hills-Mallee Fleurieu, 2 Greater Green Triangle

GPs and specialists teaching in the program (coded as Clin)	126	42	GPs: 4 Mildura, 8 Gippsland, 12 FURCS Specialists: 2 Mildura, 3 Gippsland, 3 Mount Gambier Hospital based medical officers, 2 Mildura, 2 Mount Gambier Hospital-based nurses and midwives: 4 Mildura, 4 Gippsland
Admin personnel from local health services, local councils, and gov community reps (coded as Partners)	62	23	Hospital CEO: 1 Mildura, 1 Gippsland; 3 FURCS Director of Nursing: 1 Mildura, 2 Gippsland, 2 FURCS Other health service administration personnel: 4 FURCS GP practice manager: 1 Gippsland, 2 FURCS Division of GP reps: 2 FURCS Staff from other UDRHs: 3 FURCS State government Minister 1 FURCS
Community members (coded as Com)	22	12	Community members: FURCS 12 (including: standardised patients, community contacts, community advisory board members, service group representatives)
Students (coded as Stud)	29	29	3 Graduate-entry Gippsland, 6 undergrad Gippsland; 20 graduate -entry FURCS
TOTAL	242	58	

Theme 1: Personal relationships

The themes related to personal relationships are outlined in Table 3. Medical students connect with private people within the RCS regions in which they are based for the academic year as they take up opportunities to test-drive country life. The frequency and quality of these individual personal relationships depends, in part, on student attitude. These relationships are also potentially facilitated by being in a smaller town, at a greater distance from the main campus, and students having ties to the town over weekends (e.g. on-call or sporting commitments). Medical students bring with them a raft of interests and expertise which rural communities' value. These include the ability and willingness to play sport, to attend and participate in service clubs, and take part in cultural events such as music festivals. In addition, some students work in the community part-time. Individual personal connections can develop spontaneously, but may also be linked

back to collective structured interactions. Administrative staff and community members with formal ties to the RCS students engage with community at a personal level by: sourcing and providing introductions to sport and extracurricular activities which align with students' interests. Partners and/or children of students are recognised as also requiring support to integrate into and enjoy the rural community.

Individual personal connections can bring mutual enjoyment for students and community members as demonstrated when long-term friendships form. The community buys in to both personal and individual formal connections with medical students with the hope, or occasionally the expectation, that these students will come back to work in the region. Students are aware of this community pressure, and can find it confronting. They can also find the community pressure motivating in terms of seeing first hand, the positive impact of their role and work.

Table 3: Individual personal relationships

Themes	Example Quotes
Students are supported and encouraged to test drive country life	<p>“it gives you a real option to see what country life is like. There’s no risk to you at all as an individual. If you don’t like it, you can go back to the city in Year 4 and follow another path” [StudF]</p> <p>“..there is a [name deleted] Community Engagement Award each year for medical students, This gives recognition to students who made an effort to become part of the community.” [StaffF]</p>
Students are supported to engage	<p>“they [the community] do take care of us so we have a positive experience of living in a small town’ [StudF]</p> <p>“If they’re a sporty type person, they will become involved in sporting clubs, we’ve had hockey, soccer, tennis. A lot of them also work in the community. They get jobs while they are up here.” [ComM]</p> <p>“the community buys in because they want doctors back here”[StaffM]</p>
Private people enjoy personal relationship	<p>“We benefited by [individual personal relationship]; he [the student] benefited by it”[ComM]</p> <p>“I found it helpful that in our situation that we were the key people that she connected with, yet within the running club there were certain people close to her own age that she also had a bond with, so it sort of extrapolated out to more than just our relationship with her. She still feels so connected to the [name deleted] community that she’ll come up here and train with them, and invite them down, you know – yeah it’s quite amazing really” [ComF]</p>

<p>Expectation that students will want to come back</p>	<p>“ The community buys into it [the extended rural placement] because they want doctors back here” [StudM] “I would consider working more peripherally. I suppose I would never have considered it if I hadn’t had this 12-15month stint and really enjoyed it. But also your lifestyle as a doctor is much better”[StudF] “They [the clinicians] are not seeing a huge amount of return on investments: that is students coming back to [region name]. Maybe for a number of social determinants like isolation, and the drought, not enough irrigation water...” [Staff M]</p>
<p>“Stud” = medical student, “Com” = community member, “F” = female, “M” = male,</p>	

within the community. Students described knowing patients and being recognised frequently outside the clinical context. Some students found the lack of privacy in this “fish bowl” environment challenging.

Some community members take on formal roles within the RCS such as standardized patients, and teaching associates. Others have roles in student selection into medical school (Flinders University Community Liaison Committee members), or in matching students to rural practices for their full-year placement. In these roles individual community members are empowered to contribute more formally to RCS core responsibilities. Pride, personal satisfaction, increased self worth and having kudos in the community through their involvement are all described as motivators to continue working with the medical schools.

Theme 2: Individual formal connections

The themes related to individual formal connections are outlined in Table 4. Medical students from both RCSs valued being recognised in their formal roles as student members of health care teams within general practice and rural hospital contexts. They were highly accepted by patients. They also recognised that they were seen to represent their clinical schools in broader roles

Table 4: individual formal connections

Themes	Example Quotes
Patients are happy to have students involved in their care	“They [patients] like to give as much as they can to the students....This morning there was one girl [in labour] delivering and she said “I want a med student because they came to our farm in second year and we taught them”. So they [the student] came in and did the delivery this morning” [ClinM]
Medical students become recognised members of the clinical team	“You actually feel as though you are part of the team...you feel like you not a burden to people. It’s an amazing difference compared to my last year that the Alfred....you’re not sitting there like a fly on the wall, you’re actually doing things....You can actually have something to do with the doctors..”[StudM] “They [the clinicians] hope that there will be competent people who can come back and look after their communities when they are not there and have moved on” [ClinM] “some of them [students] actually follow through on patients they have, because they become involved and interested in their care” [ComF]
Medical students become recognised members of the community	“[student name] and I were in the newspaper, and a member of the community ended up calling the medical clinic in the morning and invited us over to welcome us to the community”[StudF] ““There was a small group [of students] who used to commute up from Melbourne on the train. One evening, a lady collapsed in the next corridor, and so there was a call over the PA asking for medical assistance. And one student said perhaps they should do it, so they ran. It turned out the lady just fainted, and they sort of calmed her down and sat there and made sure of her A, B, Cs and everything. So all was fine... And as they walked back to their seats they heard a group of women say “They’re our Gippsland medical students”” [StaffM]
Medical students have formal roles within the community	“Some get involved in tutoring high school students....[and some were] involved at the special school last year to work with teenage boys” [StaffF] “I take them off to Rotary...and they come along and they sit there and they smile and they’re talking to people next to them. The Rotary club is just delighted. They feel like they are contributing to this student’s development. Again, it is small town stuff, but there’s a real buzz.” [ClinM]

Individual community members take on formal roles within the rural clinical schools	“My involvement is probably something that only would happen in a small community... My GP talked about the program and I came in as a mock patient for young doctors. Now I’m working as a peer supported for mental health and we’re actually able to have some students actually come out on a home visit with our clients.”[ComF] ““We’re making very, very important decisions..I guess it makes you really stop and think about making decisions, and how important they can be for people....I’m aware of the responsibility that I’ve been given” [ComM] “I am very proud that we do what we do...it is a great experience and we endeavour to never come out of character and they think most of the time that you are actually real, that you are a patient” [ComF] ““We set some funding aside to put on a lead community contact. So, She’s like a community development officer or, really she’s our professional community advisor...and she’s a very very dynamic woman who is on lots of national panels and quite an icon in rural life.”[StaffF2]
“Clin” = clinician, “Stud” = medical student, “Com” = community member, “Staff” = RCS academic or administrative staff, “F” = female, “M” = male.	

Theme 3: Collective structured community engagement

The themes related to collective structured community engagement are outlined in Table 5. Some collective structured community engagement is University driven with the intent to engage students within the community to develop support networks and prevent social isolation. At FURCS the Community Contacts Program is comprised of a designated group of

community volunteers who take responsibility for linking students into the community. This is led by a lead community member who has overall responsibility for the program and for advising the school. At MUEGRCS, members of the Community Advisory Board conduct an external evaluation of the students' experience each year. They meet privately with the students to gather data on their rural experiences and report back to the school with recommendations.

Other collective structured activities aim to broaden the local base of community members with awareness of and buy in to the RCS programs, who can then advocate for the programs. Collective structured engagements include: student welcome receptions, Community Advisory Board meetings, and providing access to the University teaching infrastructure for local health and education programs.

Finally collective structured activities, such as clinical faculty meetings and mock student clinical exams, seek to engender a sense of belonging for local clinicians whose teaching roles are essential to the ongoing viability of the RCS programs.

Table 5: Collective structured community engagement

Themes	Example Quotes
Facilitate student networks	"we started a couple of years ago as community contacts...they know we're there. We make a point of trying to have a cuppa with them, or we've had them round for dinner, or took them to Jazz, or whatever." [ComM]
Broaden community awareness and buy-in	"Every medical clinic has a poster up on the wall so that lets the patients know that there are medical students around" [PartnerF] "the first things I did was to run workshops on how to do research and how to engage communities...it was about getting people's ideas to start with" [StaffF2] "Apart from the education we provide the students and junior doctors, last year we provided 3000 additional hours in this [rural clinical school] building, of education for community groups and to the hospital...and paramedic groups." [StaffF]
Encourage informal advocacy	"I have knowledge that others don't have and so I can advocate for the University...We know how long it takes to get people through the system, but the expectations of the community generally are that we're going to get more GPs" [ComM]
Clinicians have a sense of belonging	"They [rural clinical teachers] are becoming some of our key contributors. So from going from a place where we needed to give them faculty development it's come back the other way. They're some of our more experienced clinical

	<p>teachers and it's interesting when I go to these one day [faculty development] sessions, and you walk into this room and they are saying "we are [name of University], we are [name of University] staff." [UniLeadM]</p> <p>" being able to say we work for [name of University], we are recognised by [name of University] is very important [ClinM]</p>
<p>"Com" = community member, "Partner" = representative of local partner organisation, "Staff" = RCS academic or administrative staff, "F" = female, "M" = male.</p>	

Theme 4: Strategic regional engagement

The themes related to strategic regional engagement are outlined in Table 6. Some activities are driven by community members and organisations and result from a strong sense of ownership of the programs by community partners such as local government, service groups and State Departments of Health. Representatives from partner organisations may provide formal advocacy for RCS programs enhancing the provision of medical school curriculum locally and supporting medical and other health professional students to live and study in rural communities. Universities link with other community organisations to build

social capacity including training the future health workforce; and creating workforce development and recruitment strategies; and increasing the evidence around clinical care in rural and remote areas. For example, in one RCS, representatives of the Community Advisory Board established a Scholarship program to assist students from the local region who were selected into medical training.

Table 6: Strategic regional engagement

Themes	Example Quotes
Formal advocacy for RCS program	<p>"it's not well known and that's one of the problems I think, is the level of awareness in our community, of what the program is, how it operates, what the community contributes to it, what it contributes to the community and I'm looking for opportunities to carry that forward"[PartnerM]</p> <p>"I've got deep relationships with community people. I could ring the Mayor at the drop of a hat and say I've got 12 academics coming from South Africa next week, please come along and help me promote the PRCC. So I'm not doing that alone. It's a whole community approach" [StaffF]</p>
Local capacity building medical and health professional	<p>"I don't know all the politics and the funding buckets, but [the] doctor took us around the practice and showed the [plans for the] expansion of...the emergency centre...and they [the rural clinical school] had somehow accessed an actual bucket of money." [PartnerF]</p> <p>"..General Practices, but also local councils local educational</p>

training	<p>institutions, and high schools...They all feed into providing the systematic answer to recruiting appropriate high school students, making them aware they can do medicine, they are supported through, they come back and that whole vertical integration thing can happen. But at the end this will really only work if the whole project in each place is owned strongly by the community..." [PartnerM]</p> <p>"with the success of the program, this model is now being implemented in the allied health professionals and paramedic training" [Staff F]</p>
Local capacity building health workforce	<p>"that was about working together as a community involving the Councils and ourselves as the Division, and all of the health services and medical practices, to sort of...make the medical workforce better in the [region name]" [PartnerF]</p> <p>"we're building up a regional [medical] workforce, which is very important in specialist areas... and so in the country we're actually creating that workforce again, and it's through having this school here....because some of the towns have a lack of social capital...like restaurants, hotels and schools " [PartnerM]</p> <p>"As part of the program we decided it would be quite good to have them [paramedic students] volunteering in health related services ideally. So they went off to [town name] and the students volunteering [as ambulance members] completely flipped the culture of the entire community such that now they've got 30 or more volunteers..."[StaffF]</p>
Local capacity building clinical care	<p>the centrally driven [health care] model doesn't fully take into account the significant impact...in terms of the town's wellbeing....There is a significant amount of professional isolation. We find that the students are actually influencing learning outcomes of the senior [medical] staff as well because they're being exposed to a lot more contemporary models of medicine" [PartnerM]</p> <p>"[student name] contacted the health service and said we need to know who the after-hours supervisors will be...so the health services absolutely had to be planning that far ahead. So it helped the health service get some leverage....It's a perfect example of the program being a catalyst for improving health services...the way students step up and learn leadership." [StaffF]</p>

Local capacity building rural health research	<p>"...,there isn't the same level of research that informs rural practice which is one of the things that we really need. I mean most of the evidence is collected in places like this [tertiary hospital], and yet we try and apply it in small, low resource settings...I think there is a huge need for really good research there. My sense is that getting that sort of engagement, not only of our staff but of the clinicians who teach..." [UniLeadM]</p> <p>"Being opportunistic about what [research] we took up. So doing things like suicide prevention in rural communities and aged care social options in rural communities....resilience and Early Learning community development program." [StaffF2]</p>
<p>"Partner" = representative of local partner organisation, "Staff" = RCS academic or administrative staff, "UniLead" = Central University academic leader, "F" = female, "M" = male.</p>	

Theme 5: Policy level engagement

The themes related to policy level engagement are outlined in Table 7. There is evidence that the RCS have made more explicit the social responsibility of their parent Universities to produce graduates who will contribute to the provision of medical services in underserved areas of Australia. Community partners express a strong expectation that RCS involvement in regional health services will reduce the vulnerability of marginal services from pressures to centralize services to save money.

Table 7: Policy level engagement

Themes	Example Quotes
Policy level influence: education	<p>“Universities weren’t taking up their responsibility. They were saying ‘We’re producing good medical graduates. Where they practice after that is there decision’. Sort of honourable washing of the hands.....but unless it [rural clinical school program] actually delivers on community goals, it will never work. So that means we actually do have to deliver on a rural workforce”[UniLeadM]</p> <p>“Extending the [clinical training] model to allied health at [regional area] sites opens up a huge potential for medical and allied health students to partake in inter-professional education”[StaffF]</p> <p>“ground floor discussions between [rural clinical school] and [State Dept of Health] around the rural medical program have clearly played a seminal role in the journey...Leadership on both sides was crucial.”[field notes]</p>
Policy level influence: rural health infrastructure	<p>“[Collaborative partnership] led to recognition from the State Government and the Federal Government fund a major hospital refurbishment...on a new site which will function as an integrated [clinical] teaching unit.” [PartnerM]</p>
Policy level influence: rural health workforce	<p>“This is a scheme that’s going to solve their [medical] workforce issues....we are getting good results, I think, but the problem is our numbers going through are small” [PartnerF]</p> <p>“In [name of small town] the association with a university is very important because state governments are always trying to rationalize services because they want to build up [name of regional centre]. But we could say ‘no you can’t close it down because we need it for student teaching’. Having the sign out the front with the University logo is kind of something important. It is something we get a bit blaze about down here [city campus], but I think it is quite important.[UniLeadM]</p>
<p>“UniLead” = Central University academic leader, “Partner” = representative of local partner organisation, “F” = female, “M” = male.</p>	

Theme 6: Interconnection

The five themes described above were clearly interconnected with individuals frequently describing roles at multiple levels of community engagement. For example, after holding the position of community contact for medical students, the Mayor of one city independently decided to support the clinical school through Council. This included funding an annual reception of students to demonstrate that the City, on behalf of the community, values the students; and to build awareness of the RCS programs within the general community. This person entered state politics, and continues to provide advocacy for the RCS programs.

Theme 7: Leadership

The final theme identified in relation to community engagement was the crucial role of leadership by RCS staff (Table 8). There was a clear sense of commitment and purpose from the administrative staff who were referred to as the unsung heroes of the program, particularly in terms of their respect for students and motivation to support them to meet their social as well as academic

needs. The central role of a small number of key individuals in the local leadership of the RCS programs was also noted.

Table 8: Leadership

Themes	Example Quotes
Administrative staff are the unsung heroes	<p>“ we are so well supported, if we miss a session they [administrative staff] will arrange another session”[StudM]</p> <p>“There is always milk in the fridge for the students”[StaffF]</p> <p><i>It became abundantly clear that the administrative staff play a vital role in the success of the RCS’s. Their commitment, enthusiasm and passion to make the program a success is remarkable. Their logistical support to the students...Extra mile examples are: helping a student to get a driver’s license, arranging for advanced driving lessons. [HC field notes]</i></p>
Committed and effective leadership	<p><i>I encountered many instances of highly committed and highly effective leaders and leadership. [JH field notes]</i></p> <p><i>I gained a strong sense that the leaders are ‘on the job 24/7’ when it comes to searching out and fine tuning ways and means of ensuring that the rural medical programs stay at the forefront of innovative medical education. [JH field notes]</i></p>
<p>“Stud” = Student, “Staff” = RCS academic or administrative staff, “F” = female, “M” = male.</p>	

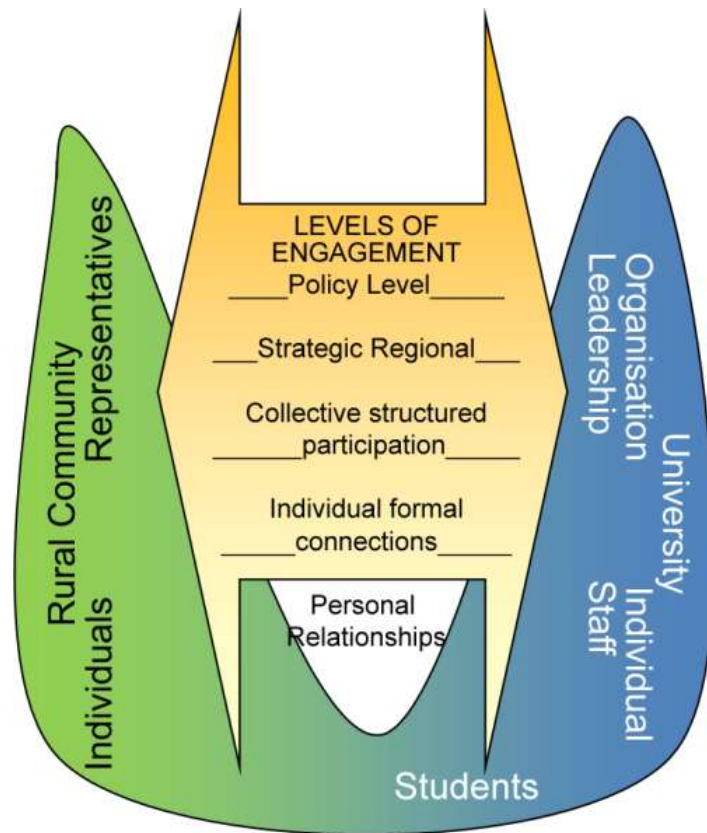
Discussion

Community-based medical education, as practiced by the RCSs in this study, consciously places medical students within a complex network of relationships described in the 4R's model of symbiotic clinical education.(Prideaux, Worley et al. 2007) The themes found in this study can be organised to represent a model of university - community engagement which recognises a spectrum of engagement levels from individual to collective influence on policy, and helps to operationalize the community-student-government axis of the Symbiosis Model (Figure 1).(Worley 2002) The levels of engagement found in this study demonstrate current RCS community engagement activities fit contemporary systems discourse in the community engagement literature, which define engagement at individual, program, institution and policy levels.(Lazarus, Erasmus et al. 2008; Kilpatrick 2009)

The new RCS parameters recognise that partnerships

between RCSs and communities can facilitate individual connections. Rural communities have a strong sense of geographical identity. It is a marker of difference between the city and the bush that individual community members, patients, doctors and community leaders task themselves with making students feel welcome.(Strasser 2010) Although it is clear that this is motivated by desires, or even expectations, that students will want to come back and contribute to the medical workforce, community members also describe immediate benefits from relationships with students. The bonding relationships between students and rural community members are clearly reciprocal in nature. Medical students are a rich injection of social capital into rural and regional communities. They frequently contribute to individuals, sports clubs, work places and community groups in rural towns. These contributions are highly appreciated by

Figure 1: Community Engagement Model



community members and partners, perhaps because young adults often leave their rural homes to progress their education and careers, reducing the collective contribution of this demographic to rural communities.(Hillman 2007)

The considerable community support for medical students results in them rapidly reporting a strong sense of belonging in these communities. This citizenship tends to engender in the students a sense of responsibility to make an impact on “one’s own community”.(Barber 2009) This form of social capital is known as bonding. Bonding is defined by close inward looking relationships between individuals with identities in common.(Mandzuk, Hasinoff et al. 2003; Arthur, Defillippi et al. 2008) By engaging in individual informal and formal relationships, students are drawn in and bonded to their rural communities. The model of community engagement outlined above (Figure 1) demonstrates this as the membership of

university and rural community are merged. These bonding relationships may nurture the formation of professionals who have a strong sense of place and purpose together with a service focus for others.(Couper and Worley 2010) Bonding relationships have been shown to promote self-perceived wellbeing.(Beaudoin 2009) Wellbeing is more than just happiness: it involves the actualisation of human potentials.(Barber 2009) In arguably the most challenging year of the medical course, RCSs must prioritize medical student wellbeing, when this group is already at such high risk of mental illness.(Goebert, Thompson et al. 2009) The study themes around individual informal and formal community engagement demonstrate the importance of and adds weight to the Commonwealth Government’s focus on ensuring RCSs engage community in the support of students.(Jones, DeWitt et al. 2005)

Providing opportunities for the community members to take formal responsibility for important roles within the school has previously been described as a key component of formal community engagement in medical schools.(Hamad B 2000) In this study activities included: student selection and student support, as well as contribution to learning and assessment activities within the medical school curriculum. Although not explicit in the study findings, RCS staff are, in the majority, recruited from the local community, further cementing the formal bonds between university and rural community. The empowerment discourse in the community engagement literature classifies participation activities in terms of power and control. The RCS in this study demonstrate examples of a Community Development Approach, supporting individuals and groups to make joint decisions and delegating some decisions to community completely. Like many Australian organisations however, community participation is

frequently seen in terms of voluntary contribution of personal resources (time and expertise) and so risks excluding less empowered groups in rural communities.(Kilpatrick 2009)

Structured engagement with a range of local stakeholders is purported to be a major contributing factor to the success of rural medical education programs.(Worley 2002; Kilpatrick 2009; Couper and Worley 2010; Strasser 2010) Activities such as student welcome functions, and hosting educational events for local community and health professionals provide opportunities to promote the university, and acknowledge contributions by locals. Collective organised activities support the development of local bridging activities. Bridging is the extent to which the community brings together people who are unlike one another, to learn from and draw on the expertise of others.(Onyx and Leonard 2010)

It has been proposed previously that distributed medical education may lead to increased social capital and therefore

contributes to the sustainability and resilience of rural communities.(Halpern D 2005) The first three community engagement themes demonstrate community capacity building through the development of intra-community bonding and bridging organisations; however, this study demonstrated RCSs facilitate bridging and bonding between rural communities and external parties. (Geys and Murdoch 2008) Bonding relationships allow local organisations to work together to improve training, health workforce, clinical care, and rural health research at local levels. Bridging relationships allow rural community partners to source new ideas and information from external parties to create local- and policy-level changes.

In this study leadership was found to be an overarching facilitator for community engagement. In each region strong leadership captured the imagination and enthusiasm of diverse groups within the community to share common goals around

support of medical education in their rural community.

Leadership has previously been recognised as an essential component for effective community engagement.(Lavernack and Wallerstein 2001; Kilpatrick 2009; Onyx and Leonard 2010) The subsequent outcome of this level of engagement and empowerment was that community members and organisations demonstrated the capacity to positively influence the role and function of RCSs, regional capacity, and the development and implementation of government policy.(Lavernack and Wallerstein 2001)

Conclusion

Rural communities have a strong geographical identity which can result in strong bonding relationships which encompass students. Community placements and community engagement as integral components of both the Flinders and Monash rural

medical programs are vehicles for nurturing the formation of professionals as individuals who have a strong sense of place and purpose together with a service for others focus. Universities can engage with community to create regional partnerships which seek to increase social capacity in regions which often self identify as under-resourced. This study provides a model of community engagement by universities in rural Australia.

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Community Health Needs Assessment: A platform for promoting community-university partnerships and research to improve community health and wellbeing.

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Abstract:

Internationally, there is an increasing emphasis on the importance of engaging with communities in order to guide and develop relevant health policy and services. Evidence suggests that community participation and involvement in the process of health research has many significant benefits. One example of community engaged health research is the process of Community Health Needs Assessment (CHNA). Community Health Needs Assessment provides an ideal platform for universities, local governments and their communities to partner together to better understand the

health and wellbeing needs and priorities of populations.

While Local Governments in Australia often have clear strategic directions based upon a continuing dialogue and engagement with the populations they represent, they simultaneously often lack the capacity and time to conduct comprehensive community engaged research from which to develop important strategies and actions. This paper draws on the experiences and reflections of the Tasmanian University Department of Rural Health (UDRH) and its partnership with five Tasmanian communities, their local governments and health services. It provides insight and reflection into how universities can be partners in inclusive community engaged research and collaboration through CHNA, and outlines the key processes and methods that inform this process.

Key Words- Community Health Needs Assessment, Community Engaged Research, Health and Community Partnerships, community health and wellbeing.

Introduction

Over the past forty years, key World Health Organisation directives such as the Alma-Ata Declaration (1978) and Ottawa Charter on Health Promotion (1986) have stressed the importance of communities having the opportunity and ability to actively participate in planning for and controlling their own health and wellbeing (Kilpatrick 2009; Fawcett 1993). These directives inherently involve governments recognising the importance of not only creating an environment that supports physical, social, economic and cultural health and wellbeing, but also ascribing significant value to strengthening community action so that communities have the capacity to set priorities and make decisions

that affect their health and wellbeing (Israel and Ilvente 1995; Anderson et al 2006; Manitoba Health 2009; Langwell 2006; Kilpatrick 2009; Hawe et al 1997; 1998; Potvin 2003).

Within the state of Tasmania, community participation in the prioritisation of community health and wellbeing services and resources is seen to be growing (Kilpatrick 2009; Kilpatrick et al 2008; Auckland et al 2007; Johns et al 2007). This trend is being driven not only by the community sector, but also by the increasing engagement agendas of local and state government as well as the University of Tasmania (Kilpatrick 2009). For example, since 1998, the Tasmanian Department of Health and Human Services and the University of Tasmania have had a unique partnership arrangement called 'Partners in Health' created to develop and maintain a strong partnership that contributes to the strategic objectives of both organisations in terms of health workforce, health research and health education. Local

Governments too, are increasingly undergoing reform changes which are putting increasing emphasis and responsibility on Councils to plan for and respond to community health and wellbeing, with many developing municipal health plans (Vic Health 2002). Community groups themselves are also increasingly taking on active roles through advisory groups and boards for municipal health services and hospitals in many parts of the Tasmania. During the past six years the University of Tasmania, Department of Rural Health has worked in partnerships with five rural and regional municipalities, their Local Government Councils and their local and regional health services in undertaking Community Health Needs Assessments (CHNA). This paper reflects on the principles and processes underlying CHNA and how this process can be used as a basis for partnership between universities and community stakeholders in order to promote

community engagement and to plan for, and ultimately improve the health and wellbeing of targeted communities.

Community Health Needs Assessment: A tool for university-community engagement and partnership

Community Health Needs Assessment is well recognised as an important platform for community engagement (Israel and Ilvente 1995; Anderson et al 2006; Billings and Crowley 1995; Cavanagh and Chadwick 2005; Hancock and Minkler 1997; Horne and Costello 2003; Jordan et al 1998). Community engagement is defined in this paper as a process of working collaboratively with individuals and through groups of people by providing them with skills needed to affect change and to address issues affecting health and wellbeing in their community. Community engagement is a way of including the views of a community in planning and decision making processes. This definition of community engagement draws strongly on concepts associated with

community development such as participation, inclusion, engagement and capacity building. It is inherently based on the principle of working with a community to identify, understand and develop strategies to address and respond to their needs, priorities and concerns. Community health needs assessment is one method or approach to community engagement. A community health needs assessment can best be defined as:

...a dynamic ongoing process, undertaken to identify the strengths and needs of the community, it enables the community-wide establishment of health priorities and facilitates collaborative action planning directed at improving community health status and quality of life (Manitoba Health 2009: 1).

Community Health Needs Assessment is a strategy which has the key purpose of collecting, analysing and presenting information so that the health and wellbeing of a particular population can be better understood, responded to and ultimately

improved. This includes an understanding of how health services are provided and consumed to better inform health service planning and provision (Manitoba Health 2009; Barrett, Woodroffe and Skellern 2007; Auckland et al 2007; Langwell 2005; Hawe 1990). CHNA's typically involve a 'social view' of health that extends beyond the dominant biomedical model of health and illness or disease, and acknowledges that social, environmental, economic, biological and gender factors all influence health outcomes and quality of life. For example, a social view of health and wellbeing can consider issues such social support networks, education and literacy, employment and working conditions, healthy child development, housing, socio-economic status, physical environment, culture and equitable access to services and resources.

There are many multidimensional benefits of conducting a community health needs assessment (South Australian Community

Health Research Unit 1999; New Brunswick Health 2002; Manitoba Health 2009; Israel and Ilvente 1995; Langwell 2006; Cavanagh and Chadwick 2007), these include: identifying, assessing and analysing specific and general areas of community health and wellbeing; encouraging collaboration with community members, stakeholders and a variety of partners involved in decision-making processes within community and population health; advocating for change; identifying opportunities for disease prevention and health promotion; empowering individuals and groups within the community; assessing gaps in service provision and access to services/ resources and evaluating how effectively services are responding to community needs, including barriers to service provision and access.

Traditionally, community health needs assessments have been driven and conducted by governments and government supported agencies as a way of identifying health issues and

planning for services and resources (Langwell 2006).

However, the ways in which this information has been gathered and used by governments has been criticised for not only the quality and validity of community consultation, but also concern over the information being misconstrued or incorporated according to professional priorities and bureaucratic pressures (Jordan et al 1998; Hancock and Minkler 1997). There has been an increasing emphasis on community involvement and participation in the process of community health needs assessment in recent decades. This trend largely reflects a growing recognition that 'in any community, local experiences, priorities and traditions are important for effective planning' (Langwell 2006:1) and that 'any identification of community need should be informed by community consultation' (Alston and Bowles 1995:127). Such moves have also inevitably opened up opportunities for not only health services but local governments and community groups to

work with stakeholders such as Universities in developing and undertaking community health needs assessments.

What's the Uni got to do with it? The role of Universities in Community Health Needs Assessment

While the process of conducting a community health needs assessment has been the subject of much inquiry, particularly in the United States (see Langwell 2006; Felix and Burdine 1995; Billings and Crowley 1995; Horne and Costello 2003; Escoffey 2004) there is very little research concerning the role of inter-sectoral partnerships in the development and conduction of community health needs assessments. The role that universities can have as both partners and researchers in this process is the focus of this paper.

Over the past 6 years, the University of Tasmania's Department of Rural Health (UDRH) has worked with five different rural and regional Tasmanian communities as well as their local

governments and health services through the process of community health needs assessment. In all cases, the UDRH has been approached by community stakeholders (hospital/health advisory boards, local government councils, health services, community groups) wishing to undertake community engaged research in both broad and specific areas of health and wellbeing. However, all were uncertain of, or limited in the knowledge, skills and technical aspects of undertaking such a process successfully. The UDRH has consistently partnered with local government councils in Tasmania to address health and wellbeing issues in different areas of Tasmania. Like many local governments in Australia, these councils often have clear strategic directions based upon a continuing dialogue and engagement with the populations they represent. However they often lack the capacity, expertise and time to conduct comprehensive community engaged research

from which to develop important strategies and actions to guide the future directions of their municipalities.

The scope for University and local government partnerships around many aspects of community health and wellbeing (services, social inclusion, transport, environment, recreation) continues to grow in states like Tasmania. Comprehensive community engaged research assists in providing a snapshot of community needs and priorities but is also an increasing knowledge base for grant and funding opportunities both nationally and locally. Universities therefore have important strengths in partnering with community stakeholders to conduct health research. From six years of partnership in CHNA's, we argue that Universities can contribute important roles and responsibilities, including the provision of:

- Technical and Expert Capacity- university staff have training and expertise in the technical aspects of conducting research.

They can assist the community to develop and implement research methods and tools to collect relevant information and possess the analytical tools and technologies to generate, analyse and evaluate information;

- Mentorship and Co-Learning- universities can build and enhance the research and program development capacity of other partners, organisational representatives and community members through involving them in relevant stages of research;
- Ethical Responsibility- University led or partnered research which involves communities and individuals inherently demands that the research is conducted in a sound ethical manner. Universities must have clearance and approval from relevant human research ethics committees before they can contribute or undertake any research. This is considered particularly important if research involves the involvement of

‘sensitive or vulnerable’ demographic groups such as young people, the disabled, ethnic or cultural minorities;

- **Objectivity and Credibility:** universities most often have a level of credibility and trustworthiness attached to their status and role in the community. Within the process of CHNA, universities are seen to be objective or to ‘stand apart’ from the political or contextual elements of a community. This enables them in part to take the role of ‘middle men’ and to analyse and collect information and make recommendations that are not biased or directed at any political agenda or sensitivity.

Universities are also able to take a leadership role in ensuring the establishment of strong formal partnerships between Councils, health services and community representatives’ who will benefit most from CHNA. Because universities, local governments and

stakeholders including community members bring diverse skills, expertise and sensitivities to address health and wellbeing (Israel et al 1998), the establishment of partnerships is essential in CHNA in providing a solid foundation for (a) the formation of relevant aims and objectives (b) the involvement and participation of stakeholders and community members in the project design and stages (c) the building of trust and reciprocity between all project partners and (d) the bridging of academic and practical knowledge. Additionally, university partnerships in CHNA are also seen as ‘good value for money’. In past evaluations conducted by the authors of the CHNA process, communities and their stakeholders have consistently identified that universities, when compared for instance with private research consultants are able to offer more ‘reasonable’ project costs. The Tasmanian UDRH most clearly differs from private consultancy because its mandate is to engage with communities and to ultimately improve the

health and wellbeing of Tasmanians. As a university department it highly values the research opportunities and outputs that partnering with communities through CHNA can produce. Additionally, the UDRH is able to subsidise as 'in kind' support project costs such as travel, infrastructure (computers, software, printing etc.) and to some degree staffing salary costs because the activity meets the requirements of core research business and can therefore be completed at 'less than market cost'. Overall, such savings provided by universities (however small or large) can significantly impact on the resourcing ability and budgets of communities and their stakeholders such as local governments, to undertake health research such as CHNA's. Along with financial incentives, universities also have strong commitments to principles of community engagement that also make them attractive partners to communities and their stakeholders in research.

How can universities facilitate and promote community participation and engagement in Community Health Needs Assessment research?

In working with any community, the Tasmanian University Department of Rural Health's has a strong community engagement philosophy based around two key principles. First, the establishment of strong partnerships between stakeholders and community groups, and second an inclusive participatory approach whereby communities work alongside the university in as many stages of the research process as possible. This approach is aimed at establishing research methods and actions that are seen as important to the community and where community members are provided with a genuine opportunity for meaningful participation (Ife 1995). The involvement of community members in the process of community health needs assessment is argued to increase the quality and validity of research by engaging with local

knowledge 'based on the lived experience of the people involved' (Israel 1998: 180).

Based on the experience of the authors, it is important however to acknowledge that keeping community members involved and engaged throughout the research process is not always straightforward or easily achieved. There are a number of factors which can impact on the willingness and commitment of community members to be involved in research. These include decreasing interest in the process, conflict with other community or project team members, a limited volunteer base, a lack of transparency and reporting, limited capacity building, no clear or perceived benefit or simply limited time. While no project can ensure that these issues will not arise, there are key processes and considerations for universities in successfully engaging communities and their stakeholders in CHNA research. The process of community health needs assessment should be based

on the community readiness and commitment, community trust in the project partners/funders, commitment to capacity building and a mixture of different consultation techniques if projects are to be successful. Each of these three principles contributes equally to the overall success and sustainability of any community engaged health research.

(1) Trust in the process and partners

The building of trust must be acknowledged and sought by universities in the process of partnering in community health needs assessment (Auckland et al 2007). Universities and their individual representatives must plan for and make time to interact and meet with community members from the onset of the project and to establish clear roles in the research process, based on inclusion, information sharing and capacity building. This has come from not only the observations of the authors but also other studies which have pointed to the ineffectiveness and

unsustainability of health promotion, prevention and assessment research stemming from researchers 'outside' the community initiating and implementing programs (Fawcett 1993). The importance of trust should be reiterated throughout the entire process for community health needs assessment, from the planning of the project and the establishment of project governance right through to the development of recommendations, actions and evaluation.

(2) Community readiness and commitment

The readiness and commitment of any community to be part of any research or engagement process is paramount. The readiness of a community and its stakeholders to undertake the process of community health needs assessment is dependent on there being sufficient and adequately developed structures to enable effective co-operation, mutual support and empowerment

(Grasby et al 2005; Auckland et al 2007). While there is no formula for developing community readiness and commitment, the authors believe that comprehensive consultation through avenues such as community meetings, stakeholder consultations and advertising in mediums such as community newspapers, bulletins and noticeboards from the planning of the project through to its completion essential. The inclusion and representation of different community members in project steering committees and project governance as well as in more 'practical' stages of community health needs assessment such as research design and data collection can also contribute to the ongoing commitment of community members. It can also increase community validation of the project and process within the wider community, because it indicates community ownership and can encourage other community members and stakeholders to participate with

knowledge that the process is being driven by a collaborative effort between the community, stakeholders and universities.

(3) A commitment to capacity building

Universities as project partners in community health needs assessment should plan for and build in as many opportunities for capacity building as possible. The term capacity building has been used extensively in the field of community and workforce development (Bowen 2000; Vic Health 2011; Hawe 1997). In the context of CHNA, capacity building is best defined as ‘an approach to the development of sustainable skills, organisational structures, resources, and commitment to improvement in health and other sectors (Bowen 2000: 28). Universities have an important role in building the capacity of both other project partners but also community members. This may entail building and enhancing the skills and knowledge of these individuals and groups in the

process and stages of research such as the design of the research tools (e.g.- developing and writing questionnaires), the collection of information (e.g.- assisting in the organising and running of focus groups or community forums, distributing surveys) and in the analysis and finalisation of results from the community consultation (the development of recommendation or action areas). Capacity building of this type has the potential to not only build individuals skills and knowledge, but to strengthen community action and empower organisations to promote sustainable health behaviours, build future partnerships and collaborations (Bowen 2000: 28) and to undertake future research themselves.

(4) A mixed method approach to community engagement and consultation

Identifying community health and wellbeing needs, priorities and issues via community health needs assessment can

take place via many different information gathering techniques or research approaches (see Butler and Howell 1980; Carter and Beaulieu 1992; Murray and Graham 1995; Alston and Bowles 1995; New Brunswick Health 2002; Felix and Burdine 1995; Escoffey 2004; Langwell 2006). While there is no 'set' way by which to conduct a CHNA there is consensus that 'the quality of the information about a community is only as good as the technique or combination of techniques used' (Butler and Howell 1980: 4). Community Health Needs Assessment should ideally incorporate a mixed method approach which includes both qualitative and quantitative data gathering techniques (Alston and Bowles 1995; Babbie 2008). Common methods used in CHNA's include key informant/community stakeholder interviews, public forums, focus groups and surveys and questionnaires. One of the most critical roles of Universities in partnering with communities and stakeholders in conducting CHNA's is not only to ensure that

appropriate methods are used to consult with and gather information from the community, but that this is done in an ethical way. It should be noted that the selection of research methods used in a community health needs assessment is obviously based on the project objectives and on the relevance of each method to these aims. Figure 1 and Table 1 below provides an overview of the key consultation methods used by the authors in conducting community health needs assessment in five rural and regional Tasmanian communities. It is important to note, that the stages in which these methods take place are varied and may be dependent on the context in which the research takes place. However, as shown in Figure 2, the authors generally use a staged approach to CHNA indicated numerically (in order of process).

Figure 1: Key research methods used by West Tamar Council and Tasmanian UDRH in CHNA

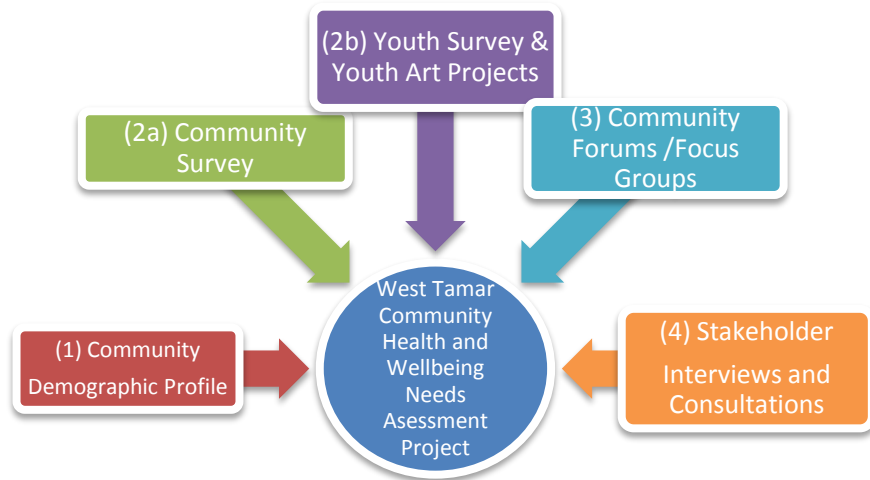


Table 1: Overview of key research methods used for community health needs assessment by the Tasmanian UDRH.

Research Method	Overview
Community Questionnaire/ Survey	<p>A structured questionnaire/survey administered by mail, community networks or online, whereby respondents fill in and return the survey.</p> <p>A method of research aimed at gathering information from all types of community members within a predefined geographical area (all ages, gender, ethnicity, suburbs).</p> <p>Questions can be broad or specific, dependent on issues relevant areas to inform aims and objectives of research (e.g. assessments of health and wellbeing, use and evaluation of services, road and community safety, youth health and wellbeing).</p> <p><i>Benefits of community questionnaires/surveys:</i></p> <ul style="list-style-type: none"> -Less time consuming and inexpensive compared with other methods; -Allows respondents to participate anonymously; -Can be distributed via a number of approaches (online, postal mail out, community network distribution); -Allows for mass distribution and return; -Can employ open-ended and closed questions to gather both quantitative and qualitative information. <p><i>Limitations of community questionnaires/surveys:</i></p> <ul style="list-style-type: none"> -Critical that questionnaire is pretested prior to distribution to ensure validity and reliability; -Traditionally low response rate for mail out surveys; -Requires software for data management and analysis (SPSS); -Results only indicate prevalence not incidence; -Ideally should be used in conjunction with other methods to give a comprehensive picture of community health and wellbeing.

<p>Youth Questionnaire/ Survey</p>	<p>A structured questionnaire/survey typically administered via schools/ youth groups and online to gather relevant information about young people.</p> <p>Designed and implemented in conjunction with relevant stakeholders in the community (i.e.- youth development officers, schools, youth groups) to ensure relevant and content and wording.</p> <p>Should include both open ended and closed questions to gather qualitative and quantitative data.</p> <p>Incentives such as gift vouchers and prizes may be used to increase participation amongst youth.</p>
<p>Stakeholder/Service Provider Interviews (semi-structured)</p>	<p>A method used to gather qualitative data whereby the interviewer engages in pre-arranged conversation with a community stakeholder or service provider (e.g.- general practitioner, child health nurse, community transport provider)</p> <p>Interviews are conducted following a 'loose structure' where a series of pre-written open ended questions are aimed at gathering information about the area to be explored (e.g.- youth health and wellbeing, mental health cases). The interviewer or interviewee may diverge from the pre-written questions in order to pursue an idea in more detail.</p> <p>Interviews typically last between 30-60 minutes in duration, and are generally tape recorded allowing for the conversation to be recorded accurately.</p> <p>Requires consent of interviewee.</p> <p><i>Benefits of stakeholder interviews:</i></p> <ul style="list-style-type: none"> -Generates rich information based around the experiences, meanings and perceptions of stakeholders and service providers about community health and wellbeing; -Provides greater insight into service provision and key issues facing service providers in particular areas; -Can be used with other methods such as surveys to complement statistical and numerical data.

	<p><i>Limitations of stakeholder interviews:</i></p> <ul style="list-style-type: none"> -Requires expertise on the part of the interviewer to enable non-bias (e.g.- not leading participants to answer in particular way, not indicating disagreement or agreement with statements); -Both interviewing and transcription can be time consuming; - Requires sensitivities to the meaning and interpretation different people give to their roles and place in a community; -Service providers/stakeholders may feel politically constrained in their comments or opinions.
<p>Community Forum/Meetings</p>	<p>A method of collecting information where community members are invited to attend a community meeting where they are asked a series of broad questions regarding community health and wellbeing.</p> <p>Typically 60-90 minutes in duration, whereby responses are noted as themes.</p> <p>Are advertised via community bulletins and media, noticeboards and via community networks and organisations.</p> <p>Can be open to all community members or run with specific groups within the community (for example- sporting groups, neighbourhood watch, church groups)</p> <p>The offering of food/refreshments is a popular part of community forums, and can increase participation and attendance.</p> <p><i>Benefits of community forums:</i></p> <ul style="list-style-type: none"> -Allows a large group discussion to occur where community members can speak openly and informally; -Generates broad themes and ideas associated with health and wellbeing -Can attract community members from a number of different backgrounds and situations; -Can be conducted in a variety of settings and environments. <p><i>Limitations of community forums:</i></p>

	<ul style="list-style-type: none"> -Community members may feel intimidated or unwilling to speak publicly about their opinions and perceptions (no guarantee of confidentiality); -Participant numbers are often hard to anticipate. -Can be difficult to facilitate a large group discussion -Requires both a facilitator and note taker as tape recording a large group discussion is often not possible. -Should ideally be run at a variety of times and places to account for different demographic groups and opinions
Focus Groups	<p>A research method used to generate rich and detailed qualitative information. Involves a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of research (Powell 1996). Typically involves a maximum of 6-10 participants and last for around an hour in duration.</p> <p>The interviewer/facilitator has a set of broad questions; however there is flexibility in these questions and group discussion is the priority.</p> <p><i>Benefits of focus groups:</i></p> <ul style="list-style-type: none"> -Allows exploration of issues via small group interaction; -Enable participants to draw on experiences and thoughts of other and to share their ideas; -Gains understanding quickly and at less cost than other methods; -Gains access to the views/ beliefs/ experiences of different groups (e.g.- single mothers, mental health workers, carers of older people); -Often utilised because of its suitability in examining 'sensitive' issues (Rice and Ezzy 2005; Patton 1990); <p><i>Limitations of focus groups:</i></p> <ul style="list-style-type: none"> -Limited in ability to generalise findings for a whole population (no statistical data); -Recruitment may be difficult/ time consuming; -Involves a level of self-disclosure/ trust/ willingness to engage in group sharing; -Can generate a lot of data, data can be challenging to analyse; -Requires skilled and well planned facilitation.

Public/Youth Art Projects	<p>A complimentary method used in community health needs assessment that involve a number of partners (particularly those involving youth) whereby the research and project team collaborate with local schools and youth groups to engage young people in art projects that reflect their interpretations and priorities for their health and wellbeing and community broadly.</p> <p>The art can take many different forms dependent on the project scope including public installations to be used in public spaces such as parks, the painting of walkways and underpasses, the creation of banners and posters for public events and a portfolio of paintings and drawings by youth in the community to be used in reports and strategies.</p>
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University Reflections on the Outcomes of Community Engaged Research through Community Health Needs Assessment

There is no doubt that the participation and involvement of communities in research has many benefits (see Israel and Ilvente 1995; Anderson et al 2006; Manitoba Health 2009; Langwell 2006; Kilpatrick 2009; Hawe et al 1997; Potvin 2003; Fawcett 2000). With respect to community health needs assessment, the authors have knowledge through formal evaluations (e.g- interviews) and anecdotal evidence of many ways in which the process and the

partnership between the Tasmanian UDRH and five communities has contributed to community health and wellbeing. While these evaluations are not the focus of this paper, the most recent partnership undertaken by the UDRH with the West Tamar community and West Tamar Council in Northern Tasmania (2010-2011), is an excellent example of how university-community engagement can produce tangible and positive actions and directions.

The West Tamar municipality has a population of approximately 20,000 is spread across 690 square kilometres, encompassing both rural and regional suburbs and townships. Over 18 months, the UDRH has worked with West Tamar Council and its community in undertaking the process of CHNA. It has involved consulting with around 1800 community members through methods such as community surveys, youth surveys, community forums, and stakeholder and service provider

interviews. Figure 2 below provides an overview of how West Tamar Council in partnership with the Tasmanian UDRH undertook the process of CHNA and how this information was then used to develop strategies and actions for responding to and improving their community health and wellbeing. For example, the information gathered through their CHNA has been used by West Tamar Council and community groups to develop a new municipality wide positive ageing strategy, community plan and social inclusion strategy. It has also strongly informed new iterations of their youth and sport and recreation strategies.

Figure 2: An example of how the process of Community Health Needs Assessment will be used by West Tamar Council to inform policies and strategic areas.



Conclusion

Partnerships between universities, communities and stakeholders such as local government through community engaged research has many multidimensional benefits and can provide a platform for better understanding, responding to and improving the health of many types of communities and their populations. Of particular importance is the increasing need to embrace a social view of health and wellness that extends beyond the dominant biomedical model of health and illness or disease, and acknowledges that social, environmental, economic, biological and gender factors all influence health outcomes and quality of life. Community Health Needs Assessment as a process is an excellent example of community engaged research in practice.

This paper has reflected on the principals and processes underlying CHNA and how this approach can be used as a basis for partnership between universities and local governments in order

to promote community engaged research and to plan for, and ultimately improve health and wellbeing in targeted communities. It showcases how universities and their expertise can increasingly play a role in building capacity amongst rural and regional communities to conduct ethical and valid research. It has also shown how CHNA can create a wealth of information that can be used to develop future strategies, actions and resources of importance to the communities and their health and wellbeing. Such engagement processes, based on principles of trust, ownership and capacity building are only likely to increase in the future, as the importance of quality and valid of community consultation becomes important in planning the allocation of services and resources. Local governments in particular, are under increasing pressure to liaise with their populations through meaningful engagement, thus reinforcing a growing recognition that 'in any community, local experiences, priorities and traditions

are important for effective planning' (Langwell 2006:1) and that 'any identification of community need should be informed by community consultation' (Alston and Bowles 1995:127). Such moves have also inevitably opened up opportunities for not only health services but local governments and community groups to work with stakeholders such as Universities in developing and undertaking community health needs assessments. However, while there is obvious scope for Universities to take a more active role in community engagement practices such as CHNA and in partnering with all levels of government to work with communities, this should always been based on a strong commitment to community ownership, inclusion and involvement, the building of capacity amongst community members and stakeholders and a mutual recognition and appreciation of both sound and ethical engagement with communities.

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Community Engagement in an Urban Community Based Medical Education program: A Case Study

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Abstract

This paper describes community engagement in a new urban community medical education program using a case study of the first community engagement activity undertaken by medical students in the program. Although urban longitudinal community based medical education is in its infancy in Australia, community engagement is equally as important in this setting as it is in the well established rural setting. The activity described in this paper was established with the principles of social accountability as the underpinning philosophy.

Keywords: Community based medical education (CBME), Community engagement, Social accountability

Background

Flinders University has a strong community engagement policy (Flinders University community engagement, 2011) and engages with communities at local, national and international levels. In line with this, the School of Medicine is actively engaged with its community stakeholders including civic leaders, local communities, clinicians and health services. The school aims to create a high quality health professional workforce to improve the health and wellbeing of society (Flinders University/about, 2011) and is a partner in the Training for Health Equity network (THEnet, 2011). This partnership of health professional schools has a social accountability mandate and its members measure success by how well they meet the needs of the communities they

serve. Community-based medical education (CBME) is one of the ways in which the Flinders Medical School aims to achieve its goal of social accountability (Frenk et al, 2010).

CBME has become an important component of undergraduate medical education in Australia since the establishment of rural clinical schools in 1997 (Rural Clinical Schools - University Departments of Rural Health Final Report, 2008). Originally driven by rural workforce requirements (Strasser, 2010) in an attempt to encourage greater uptake of rural practice, rural clinical schools have been shown to produce graduates of high standard (Worley et al, 2006).

The role of the community in rural clinical schools has been actively fostered. Medical students placed in these settings are encouraged to participate in local activities such as sporting teams, charity events and social networks, while the community is asked to provide support for students and visiting clinicians by helping

with issues like accommodation and employment. For an example of this, see University of Tasmania Rural Clinical school website, <<http://fcms.its.utas.edu.au/healthsci/rcs/cpage.asp?lCpageID=141>>. Students become comfortable and familiar with the rural lifestyle, and learn medicine in the context in which it is hoped they will eventually practice. This model of community engagement is characterized by a shared long-term commitment between the University and a geographically defined, diverse, community group. It involves students and rural community members in both formal and informal relationships that help bond the student to the rural community and creates benefits for both student and community. Rural CBME programs with this type of community engagement are now well established in rural and remote centres across Australia, and are supported by significant Commonwealth Government funding (University Departments of Rural Health Program 2011-14)

In urban Australia, CBME as a substantial alternative to learning in tertiary hospitals is still in its infancy. Although perhaps not disadvantaged to the same extent as remote areas, metropolitan areas of low socio-economic status (Australian Bureau of Statistics Social Atlas 2008) are still often relatively under-served compared to more affluent areas. It is reasonable to postulate that, as with rural clinical schools, providing training in these areas of relative need might have an effect on location of future practice and help address such needs (Worley et al, 2008). In 2009 therefore, Flinders University established a pilot suburban CBME program based in a relatively disadvantaged area of outer suburban Adelaide. The new program, called the Onkaparinga Clinical Education Program (OCEP) is located at Noarlunga Centre in the City of Onkaparinga. This council contains three statistical local areas that rate within the ten most disadvantaged areas of

greater Adelaide .(Index of Relative Socio-Economic Disadvantage 2011; Australian Bureau of Statistics, 2010).

In the pilot program during 2009-10 students undertook longitudinal placements over 40 weeks in local general practices, augmented by emergency and specialist experience at Noarlunga Hospital, a community hospital of 111 beds.

After a two year pilot phase, the modified and expanded Onkaparinga Clinical Education Program was formally launched in 2011, operating from a Commonwealth Government-funded purpose-built facility opposite Noarlunga Hospital. Students in OCEP 2011 undertook a 20 week longitudinal integrated program in clinical placements with general practitioners, local specialists and allied health professionals, as well as regular placements in the Noarlunga emergency department.

Following this, students rotated through five 4-week specialty placements, three of which were based in the local community at Noarlunga Hospital and two at a tertiary centre.

A new component of the program in 2011 was the community engagement project. During the 20 week community term, students were asked to undertake a project with a focus on social accountability, in line with the Flinders University Medical School's aims. This paper describes the progress of the OCEP community engagement project in 2011.

Community engagement as a component of the Onkaparinga Clinical Education Program

During the pilot program there were no structured community engagement activities for students. With the commencement of the expanded program in 2011, community engagement was incorporated into the program, with a particular

focus on social accountability as opposed to the bonding model of community engagement used in the rural clinical schools. During the non-hospital semester in 2011, all OCEP students (who as graduate students have existing skills as well as their developing medical knowledge) were expected to participate in a community engagement project in which they used their skills and knowledge to benefit a community group in some way. The aim of the activity was to enable students to provide a valuable service to a community group while also learning, or developing further, some of the core skills and values that are expected outcomes of the medical course at Flinders University. These include: an understanding of individual and community concepts of health and illness; the ability to work in collaboration with patients, carers, colleagues, and other stakeholders; development of skills to assess public health problems and resolve them with communities; the application of health promotion and disease prevention principles

to clinical practice; and development of skills to teach others. Time was specifically allocated in the timetable to support the activities chosen by the students.

One early challenge was the definition of OCEP's community. OCEP students undertake studies within a geographically large area, with some 60 kilometres separating the northern and southern-most student placements. The geographical concept of community is not as well defined as in a rural setting, and the population of the Onkaparinga region is large and diverse with around 150,000 people (City of Onkaparinga, 2010). As an outer urban area, OCEP's community is a co-location of multiple community groups, where "communities" are of people with particular interests (Delanty, 2010) in common, such as religious or cultural characteristics, or with particular health-related needs.

OCEP's community engagement activities in 2011 are described, and a more detailed description of one of the projects,

the Falls Prevention project is given. This project had the largest student and community involvement and represented a true collaboration between OCEP, a community health service provider (GP Plus Aldinga) and individual community members.

OCEP community engagement projects

Initial projects were identified by OCEP and community partners; however, students were also encouraged to develop proposals that met their own skills and interests. All projects had to have an identified clinical supervisor and approval from, and if necessary supervision by, the relevant community leader. For example, projects in school settings had to be approved by appropriate school staff, with clinical content overseen by a clinical supervisor.

1. Individual student-initiated community projects

Flinders graduate- entry medical students already have a wide variety of prior experience and skills, and this was reflected in some of the activities that students chose to undertake.

Examples included:

- a) Continuing a volunteer activity with an organisation that provides support, advice and assistance to young women with eating disorders;
- b) Establishing a walking group for young mothers (under guidance of community physiotherapist);
- c) Delivering sexual health education classes at a local high school (under guidance of GP and school teachers); and
- d) Volunteering at a shelter for homeless men.

2. Projects initiated by OCEP in collaboration with community partners

a) *INSPIRE Program: Mentoring for school students*

Inspire is a well established mentoring program run by Flinders University <<http://www.flinders.edu.au/careers/services/mentor/inspire.cfm>>. University students provide mentoring and teaching to school students at participating schools under the guidance of staff from the University Careers and Employers Liaison Centre. It offers school students a young adult who can provide an unbiased ear, scholastic support and a positive role model. The program is aimed towards young people and children who are disinclined or at risk of disengaging from their education, with goals of increasing school retention rates and developing a stronger culture of learning. Several OCEP students chose this activity for their community engagement project.

b) Christies Beach High School - OCEP Wellbeing Centre Proposal

Christies Beach High School is a large, relatively disadvantaged secondary school located across the road from the OCEP teaching facility. In addition to the socio-economic disadvantage already described in this region, many of the school's students are educationally disadvantaged. Around 19 per cent of the school's students are on Negotiated Education Plans, nearly 10 per cent of the students are Indigenous, and 70 per cent of families receive Government assistance for education (Christies Beach High School, 2011).

There is overwhelming evidence that educational attainment is the key contributory factor linking socio-economic and employment outcomes; that the reduced employment opportunities and increased living costs that are associated with physical illness and medical conditions can be significant causes of

poverty; and that poverty exacerbates both physical and mental illness (Parliament of South Australia *Poverty Inquiry*).

Liaison with staff at Christies Beach High School identified a keen desire by the school to establish a "Wellbeing Centre" for school students. In such a Centre, school students would be able to obtain health and lifestyle-related advice, counselling, mentorship and guidance in a safe and familiar setting. OCEP has received a grant from Flinders University to explore the possibility of OCEP medical students, under close guidance from appropriate professional staff, becoming involved in provision of some of these services in such a Centre. Although the proposal is still in the very early stages of development, a Project Officer has been engaged to lay the groundwork for a Wellbeing Centre and to establish clear guidelines, protocols and procedures for the Centre. It is envisaged that liaison with many groups will be required, including but not limited to Second Story (a local youth health service), Education

Department, general practitioners, school counsellors, paediatricians, mental health service providers, and not least, students and staff of OCEP and Christies Beach High School. OCEP 2012 students will be involved in further stages of planning.

c) Falls prevention project

In partnership with staff from a local community health centre, GP Plus Health Care Centre Aldinga (abbreviated to GP Plus Aldinga), OCEP developed a Health Promotion activity in which OCEP medical students would work with staff at GP Plus Aldinga to develop and provide a falls prevention activity in the local community. As the best developed of OCEP's community engagement projects to date, this is now described in more detail in the Case Study below.

CASE STUDY: The Falls Prevention Project

The "Falls Prevention" project concept was developed jointly by staff from OCEP and GP Plus Aldinga. This facility is located at Aldinga Beach on the urban-rural fringe, and is about 25 kilometres south of Noarlunga Centre where OCEP is based. The project offered an opportunity for medical students, in collaboration with staff at GP Plus Aldinga, to develop a Health Promotion Community Program as part of Falls Prevention Month in April 2011.

The aim was for students to plan programs such as risk screening, risk assessment and community education for older people, carers and the general community, and to raise awareness of falls risk for older persons. They were also expected to liaise with local general practitioners and allied health providers to ensure good communications for patient care were maintained.

Following the initial pilot community activity undertaken by the students, the project was awarded a grant by Flinders University to enable its continuation during 2011. The project is still in progress, and formal evaluation will be undertaken in 2012.

Planning the Falls Prevention project

The broad outline of the project was established in discussions between the GP Plus Aldinga and OCEP project leaders. The approach and methods to be used were determined by medical students over the course of several planning sessions and with guidance from health professional staff. It was suggested that students consider offering educational sessions to various community organisations such as senior citizens groups and residents of local retirement villages, hold a stall in the local shopping centre to raise awareness or run a falls risk assessment day at GP Plus Aldinga. Students chose to plan and implement

community education sessions in several locations. Professional oversight was provided by occupational health and physiotherapy professionals with advice from general practitioners.

A small group of students worked initially to:

- develop and plan activities and engage stakeholders and partners;
- contribute and provide support and resources to implement the activities;
- implement activities during Falls Prevention Month in April 2011.

As well as OCEP and GP Plus Aldinga staff, the project was supported by the expertise of other local service providers from the southern area including SA Health Pathways to Independence program and Domiciliary Care SA. These community health

professionals provided guidance, expertise and support for students, enabling them to implement a program plan that was relevant, safe, and within their medical and educational experience. Although overseen by staff, it was seen as important for the project to be driven by the students. Thus, while OCEP and GP Plus Aldinga staff provided the framework and resources, the program itself relied on the students' participation, initiatives and implementation.

Activities developed by the Falls Prevention pilot project

The initial pilot was undertaken by four students. They developed a presentation which was divided into four parts.

- The facts around falls
- Who is at risk?
- Self Assessment
- Where to go for help?

Each student presented one segment, and the presentation was given twice in April 2011, once at a local retirement village, and once at GP Plus Aldinga. The presentation at the retirement village was well attended with 20-25 participants. The second presentation attracted a much smaller audience, perhaps illustrating the value of going to your audience rather than asking them to come to you. The second presentation did, however, elicit a request for the students to give their presentation to a different community group.

At each presentation, the audience was encouraged to fill in a simple 10-question falls risk questionnaire, adapted from an online self-assessment available from Falls SA (Falls prevention in SA, 2011). If audience members identified themselves as 'at risk', student-drafted letters were available for them to take to their GP for formal assessment.

Further development of the Falls Prevention project

In June 2011, a second group of students commenced their community semester, and took over the Falls Prevention project. Ten students elected to participate over the course of the semester, with 4-5 students working on the project at any one time. The presentation has been further developed with a video segment added and more resources produced. There have been requests from a Men's group and a non-English speaking group for further presentations, indicating the level of community interest in these types of health information sessions.

Evaluation

Although routine internal course evaluation using post-activity surveys has been undertaken during 2011, formal qualitative evaluation of OCEP's community engagement activities

will be undertaken early in 2012. This will involve questionnaires and interviews with students and community partners.

Findings & Discussion

Preliminary informal responses from community and student respondents indicate that the project has been positive for both parties:

Community Views:

"Working in partnership with OCEP and the...medical students to undertake a Community Development (sic) project provides benefits to all participants. The community gains valuable contact with future medical professionals and health information, the students gain a primary health care perspective different from their clinical focus in teaching hospitals and GP Plus Aldinga benefits from new and exciting initiatives and relationships. I hope the community development module will continue to develop for future cohorts of medical students."

Staff member GP Plus Aldinga

Student Views:

"I think this is a valuable program getting us out of the hospital and into the community to see how the real world works"

OCEP Student

OCEP is a new community-based program with a commitment to community engagement and social accountability. Our aim is to help students to develop and embrace moral principles of caring and understanding for patients (Branch, 2000) through a transformative learning process (Mezirow, 1991).

The initial Falls Prevention Project has provided OCEP students with an invaluable learning activity in a primary health care setting. This is consistent with the expected outcomes of the Flinders University medical program. They have had an opportunity to learn about prevention and early intervention and some of the impacts of the social determinants of health and illness

in society. The students have also been able to be direct and active providers of a useful resource, which it is hoped has increased their connection with, understanding of, and sense of place in, the community in which they are learning.

For its major community partner, GP Plus Aldinga, the Falls Prevention Project has provided additional support to allow them to further build capacity in community health education, while for the community the project has provided a primary healthcare early intervention and awareness program for older persons who might be at risk of falls and for their carers.

The Inspire program and the student-initiated projects have enabled OCEP students to use their skills and knowledge to benefit a variety of groups in the community. The proposed Wellbeing Centre at Christies Beach High School represents an intention to make a long term commitment to community

engagement and social accountability in a mutually beneficial working relationship between OCEP and the High School.

Conclusion

OCEP is committed to enabling students and our local community to have a strong, mutually beneficial engagement, and for the program to be a contributor to the community while students undertake learning in and from the community. To guide further development of OCEP's community activities, the recommendations of the World Health Organization for community based education programs are acknowledged. These include: involving the community in an active rather than a passive role, exposing students to community resources related to health care, broadening students' perspectives by familiarizing them with the family and community context into which health care must fit, and giving students feasible skills for functioning at the level of the

community (Williams et al, 1999). Through the community project activity, OCEP hopes to provide medical students with an understanding of context-specific population health needs, community-oriented medicine and public health, and to further promote a culture of social accountability.

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