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Preparing Allied Health Students for Culturally Responsive Interprofessional Practice in Remote Northern Australia

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Abstract

University students, working with First Nations communities, need to build skills in culturally responsive practice. This study explores the experience of allied health students completing service-learning placements in First Nations communities. A qualitative post-placement study was undertaken. Semi-structured interviews were completed with allied health students (n=27) from Australian universities. Data was thematically analysed using inductive and deductive analysis. The settings were healthy ageing services in two remote northern Australian First Nations communities. Students received interprofessional, discipline-specific, and cultural supervision and training. Three key themes emerged: Readiness for remote practice; cultural supervision and practice; and learning and skill development. Further, the experience of immersive service-learning placements in remote First Nations communities appear to support the transformation learning process required to build knowledge, confidence, and skills to engage in culturally responsive practice. Results could inform university curriculum to better support students to prepare for rural placements, and identify resourcing requirements while students are participating in culturally immersive placements.

***Keywords**:* Work-integrated learning; service-learning; cultural safety; Indigenous; education and training; Aboriginal; Torres Strait Islander; First Nations.

Introduction

In direct acknowledgement of the difficulties in attracting and retaining a health workforce in rural and remote Australia, University Departments of Rural Health (UDRH), through the expansion of the Rural Health Multidisciplinary Training Program, have been tasked to deliver interprofessional placement experiences for allied health students (Stewart, 2023). The underlying principle is that such placement experiences will help build a graduate rural and remote workforce with the skills and attributes required for rural practice (Battye et al., 2020). Clinical placements in rural or remote settings are effective in attracting graduates to these communities (Campbell, Farthing et al., 2021; Campbell, Kennedy et al., 2021). Although longer placements in medicine appear to be more effective in promoting a rural workforce, in allied health, the influence of placement length is inconclusive, and research suggests the quality of the placement experience plays a more significant role (Seaman et al., 2022). Placement quality for rural students is not well defined (Green et al., 2022); however, a relationship exists between student expectations, reality, and satisfaction (Tomlinson et al., 2023). Anecdotally, students that preference rural and remote locations in northern Australia, often do so because they expect to learn skills in delivering health care to First Nations people and communities.

Service-learning is a practice-based placement model that has grown across northern Australia to address vital gaps in rural and remote allied health services and provide students an opportunity to work with First Nations communities to address local needs (Campbell et al., 2020). Service-learning placements attempt to balance the student's learning needs with the needs of the community or host organisation and are often seen as a sustainable interprofessional education tool (Craig et al., 2016). These placement models have been reported to strengthen work-readiness in students, fostering skills in problem-solving and self-confidence, to name a few (Jones et al., 2015). What is less well known is what is required for skill development that is more specific to the cultural context of First Nations communities.

Developing culturally responsive practice as a healthcare professional is a lifelong process that requires constant examination of one's assumptions, beliefs and attitudes that contribute to negative consequences of marginalisation such as racism (Muller et al., 2024). Cultural responsiveness is the term used by Indigenous Allied Health Australia (IAHA) to describe the transformational method (action) by which cultural safety can be achieved and maintained (IAHA, 2019). Transformational learning theory asserts that learning occurs by shifting individuals' frames of reference via critical reflective practice (Mezirow, 2000). Culturally responsive practice is a dynamic process, depending on self-awareness, one's role and the individual, community or organisation engaging with health services. Depending on their life experience, students are often at the start of this process, learning to critically reflect on the 'Western' approaches to health care and to consider what practice shift is required to deliver culturally safe services.

This study aimed to explore the placement experience of allied health students in two remote Aboriginal and/or Torres Strait Islander communities (hereafter respectfully referred to as First Nations). The purpose of this enquiry is to build evidence to support future program design and delivery that supports students to be successful in developing skills that meets the needs of First Nations communities.

Methods

A qualitative research design using semi-structured audio-recorded interviews with allied health university students undertaking service-learning placements was conducted. Placements took place in two very remote communities in northern Australia (Australian Government Department of Health, 2020), one in Queensland (Qld) and one in the Northern Territory (NT). Both regions have a larger mining town where the local hospital is based. The services reported in this paper are primarily delivered in surrounding First Nations communities. The Qld communities also have a population that identifies as Torres Strait Islander people. Ethical approval was obtained by the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (Ref: 2021-4103) and the Far North Queensland Human Research Ethics Committee (HREC/2018/QCH/46467–1291).

Service-Learning Placement Model

The two placement programs and the experience varied for students depending on discipline requirements. All students travelled between 1000-3000kms plus from their homes to attend placement. Both settings used an interprofessional model where students from different disciplines contributed to delivering an allied health healthy ageing service for the communities. The NT placement supported up to three placements, eight weeks in length of four physiotherapy and speech pathology students. The Qld placement cohort ranged from two to six students at any one time. The placement length ranged from 5-14 weeks and included physiotherapy, occupational therapy, social work, nutrition and dietetics, and speech pathology disciplines. Supervision included discipline-specific, interprofessional and cultural mentorship. Students provided group and

individual healthy lifestyle interventions in collaboration with community organisations, including balance and mobility programs, falls prevention and functional communication (Cairns et al., 2024). A full description of the service models has been previously published (Barker et al., 2022; Cairns et al., 2024).

The development of the two service-learning placements, the co-design and co-creation process and the client experience of the service models have been reported previously (Barker et al., 2022; Bird et al., 2022; Cairns, 2022; Sarovich et al., 2022). Co-creation of both services involved a pragmatic iterative process guided by IAHA leadership with local community organisations and community members. Co-creation of the day-to-day service model involved continuous reciprocal engagement between local cultural consultants, service users and their families, staff of community organisations, students, supervisors, placement coordinators and a site administrator (Barker et al., 2022).

Cultural Responsiveness

The IAHA Cultural Responsiveness in Action Framework (Indigenous Allied Health Australia, 2019) was a guiding framework for service design and delivery (Barker et al., 2022; Cairns et al., 2022; Cairns et al., 2024). Although each site had some variation in its application, the cultural responsiveness framework was embedded in practice at both sites through student and staff local cultural orientation, minimum weekly cultural mentoring, and embedding of First Nations leadership within the service by visible partnerships with First Nations organisations, on-staff cultural consultants and mentors, and First Nations allied health co-worker roles (also referred to in health services as Indigenous Allied Health Assistant). Students consistently worked alongside First Nations staff to deliver a service that was strength-based and focused on holistic wellbeing for individuals and families as well as community development and capacity building through shared quality improvement activities, education and training for local community staff and resource assess and development (Barker et al., 2022; Cairns et al., 2022; Cairns et al., 2024). Both services prioritised developing respectful relationships, and students observed and practiced using Yarning to establish mutual respect and understanding from which a therapeutic service could be delivered. Yarning is, in its essence, storytelling and a means of communication unique to Australian First Nations communities which is relaxed, informal and non-linear (Geia et al., 2013).

Procedure

All allied health students involved in the service-learning community placements, n=14 from Queensland (Q) and n=13 from Northern Territory (N), were invited to participate. Queensland students completed placements in 2018, 2019 and 2020, while NT students completed placement in 2022. At the end of their placement, participants were invited by their placement supervisor to participate. Recruitment was independent of any assessment, occurring after all placement requirements were completed. Contact details of interested students were provided to each site's lead Principal Investigator (PI). The lead PI contacted the students via email and/or phone, provided participant information and obtained appropriate consent for the research study. It was clear to students at every interaction that participation in the research would not impact their university grades or future work opportunities. Interviews were scheduled no later than two weeks post-placement; most were conducted via telephone or video conferencing, and all were recorded. Interviews were semi-structured and lasted between 30-60 minutes. All interviewees were first asked to describe their experience of the placement and were then prompted to describe what they did on placement, how prepared they felt for the placement, how they felt about the delivery of the service, including supervision arrangements and other student peers, and what they learnt from the experience.

Data Analysis

Using an inductive qualitative coding approach (Linneberg & Korsgaard, 2019), the transcribed interviews were coded by three researchers (AC, CR, DM). One of the researchers (AC) then used the codes to develop high-level themes and subthemes that were iteratively agreed upon by the other coders (CR & DM). The coding, themes and subthemes were then reviewed by a fourth researcher (NC) to resolve any points of dissent and confirm the themes and interpretation of the data. Participant codes for each quote are provided Q=Queensland, N=Northern Territory. The data was then deductively applied to the IAHA cultural responsiveness framework (2019), with examples from the student experience coded against the six cultural capabilities described in the framework.

Results

All 27 students consented to be interviewed. To preserve anonymity in such a unique and small sample, gender and cultural background were not collected.

Table 1 shows three major themes incorporating 13 subthemes that emerged from the data. The three major themes were readiness for remote practice; cultural supervision and practice; and learning and skill development.

Table 1

Themes and Subthemes in the Student Experience Interviews

Themes	**Readiness for remote practice**	**Cultural supervision and practice**	**Learning and skill development**
Subthemes	Preparedness	Learning about culture and language	Personal growth
	Understanding the remote health context	Communication and 'two-way learning'	Interprofessional practice
	Diversity of role	Cognitive load of cultural uncertainty	Learner burden
	Integration with other services	Student integration into culture	Patient centred practice

Readiness for Remote Practice

Preparedness

Allied health students overwhelmingly reported that service-learning placement helped them feel more prepared to be clinicians. The students experienced a trajectory from initial nervousness, particularly related to the unfamiliarity of the remote and First Nations health setting, to functioning as independent clinicians, utilising appropriate level technical and interprofessional skills. Despite initial reservations about the service-learning model, which one student described as "floaty", the students came to value the independence and responsibility. They saw that in the process, they had learned broader management skills:

> We're very used to essentially having a safety net to fall back on all the time while we are on placement…and I didn't feel prepared when I initially got there…But the more time went on, I realised that I had the skills, I knew what I was doing. (Q1)

A mind frame of accepting that things will not always be smooth was noted as helpful when preparing for the placement, whereas other students spoke of feeling less secure and needing more structured guidance and support. Admitting to struggling took courage but was appreciated by others who felt similarly:

> It was only when someone said, "Actually I felt a little bit nervous there," … that suddenly everyone else would start sharing their experiences, which was really valuable. (N6)

Understanding the remote health context

Students consistently reported that their placements increased their appreciation of the challenges faced by people living in remote areas. Students observed how equipment access, medication access, and profession-specific service availability were much less than what they had observed in previous metropolitan placements. One student did not realise that the small local hospital did not have the full range of allied health professionals. Another student referred to the context as "almost a developing country", while others used the words "shocked" or "strange" to describe their reaction.

Compared with their prior metropolitan experiences, students also reported a greater appreciation of the challenges presented by routine tasks such as arranging appointment times. They described complications such as patient lack of phone access, geographical distances, and limited understanding of the allied health role in a primary healthcare team:

> A lot of driving. A lot of chasing up people, finding people. Communication's very different because a lot of people don't have phones … (N9)

Students came to understand and value the differences in the service delivery model which prioritised relationships with people rather than the routine of structured time allocation for clinical work. Initial surprise and a sense of failure (N5) when achieving tasks wasn't the priority changed to acceptance and embracing of the relationship-based model because of its importance to the community:

> I'd come from this structured environment, where every half hour boom-boom-boom… I loosened my reins of control … I was just like, 'just let it go'…. and then … I found that I was able to enjoy myself more…when I was just…stop worrying about the time. (Q9)

Students quickly developed an awareness of the realities of managing disabilities in remote communities but reported that the strengths of culture minimised some of the impacts. One student talked about signing as a communication form, which greatly minimised the disability of a service recipient with severe hearing loss:

> Here everybody knows Yolŋu sign language. Everybody uses it. They will use it just to communicate over distance. Everyone uses it to communicate with everyone. (N12)

Diversity of role

Students reported a greater appreciation for the diversity of the generalist role of allied health professionals working in remote communities. Students identified aspects of the role essential for remote and First Nations communities, including health promotion and community development. Addressing social disadvantage and determinates was a crucial element in both service-learning models. This involved addressing core human needs first, such as food, security and access to services:

> In a [urban] clinic you're advocating for … health, physio-based things. Whereas here, there's so many external factors like, transport, money … you need to advocate for to have a successful session with a patient ... you call people around, make sure money gets put into the account, and then go with them, buy the groceries. All those things that are additional parts of your role. (N9)

One student described this as addressing "quality of life". Students noted that the role of allied health professionals in the public service based at the local hospital was very different from that of community-based service-learning services. Even short exposures to the local hospital staff and services appeared to provide a benefit to the students because they could then better understand how the community experienced hospital services:

> [It] was good though for me to understand what a hospital experience looks like for an Indigenous person, because it's … quite different. (N4)

Integration with other services

The students spoke of the interprofessional supervision and observation opportunities they received from a range of clinicians, including hospital-based professionals, as being informative and helpful in broadening their access to the community and their understanding of roles and responsibilities. As a newer service, the service-learning placement in the NT was still building relationships with the public health service. Students discussed wanting "more connections" to avoid potential overlap and ensure appropriate client follow-up. All students recognised that the holistic and regular interventions they were offering could not be provided by the visiting professionals and recognised the value-adding to health outcomes for clients. For example, one student worked with hospital staff to improve the continuity of care for a patient with a mealtime management plan, ensuring that the patient was able to access that plan while in the hospital despite having no hospital-based speech pathologist.

Cultural Supervision and Practice

Learning about culture and language

Despite some cultural training and pre-reading before placement, many students reported that they were not well prepared for working with First Nations people or had to "unlearn" some things. For some, this uncertainty was okay, however others experienced culture shock for which they were unprepared:

> I learnt a lot about the Aboriginal and Torres Strait Islander cultures, ways to communicate and different rules they have in their culture. (Q11)

The students discovered they needed to understand cultural norms and ways of working with individuals, their families and decision-makers who can speak for others. The cultural advisors and First Nations' allied health co-workers were critical for student learning. In general, students understood that cultural learning was an ongoing process and described the importance of being immersed in the culture:

> You spend a lot of time in community and a lot of people have been really welcoming, really eager to share what they know about their culture. (N11)

Communication and two-way learning

Learning how to gather clinical information in a flexible and culturally responsive manner was a consistent theme among students, and learning and using some of the local language was seen as a beneficial communication strategy. All students talked about the importance of learning how to Yarn with clients and their families:

> A [clinical Yarn] … it's going back and forth rather than just, 'Tell me about this, tell me about this…it's keeping your [discipline] hat on whilst you're having a conversation, and getting the bits and pieces that you need to know but also learning about the person's story' (N9)

Two-way learning created mutual respect and a different relationship hierarchy compared with a Western model. This involved the cultural educator or a community member/client sharing about culture with the students, as the students shared their clinical skills:

> The biggest thing that a lot of [clients] have said is that they want to educate us on their culture. We are helping them as much as they are helping us. (Q8)

Cognitive load of cultural uncertainty

Some students struggled with a perceived lack of control of their workload and uncertainty with their role. Unlike an urban clinic, the pattern of work in remote First Nations communities is very much dependent on what is happening in the community, for example, if there are ceremonies underway. One student described this as an additional "cognitive load" to carry; another student said it was draining to juggle clinical and cultural learning and apply both simultaneously:

> You've got to build the connection in a culturally safe way, learn about their language, their history, their family. You're trying to learn all that on top of clinical thinking. (N9)

A specific example a student gave was trying to ensure culturally appropriate seating configurations in groups to show respect for poison brother and sister relationships. Poison relationships are part of First Nations kinship systems in which certain relatives are taboo and should be avoided. The cultural educators on the project supported the students through this uncertainty, and a student suggested that additional mentoring, either by a local person or by a First Nations person from another region, would be helpful. Sharing their uncertainty with other students as peers was also supportive.

Student integration into culture

The students clearly articulated that they had felt welcomed by the community at large and felt privileged to be invited by the communities to learn about culture through participation experiences: "People are really eager to share what they know" (N12). Participation immersion included spending time together, allowing relationships to develop. Meaningful activities reported by the students that indicated a level of community acceptance and integration included picnics with the women, invitations to attend ceremonies and dancing, or activities such as spearfishing and learning about client-specific cultural information such as totems.

Many students commented on the need for extended relational time to become accepted and integrated into the community. These comments suggested that additional placement time could be helpful and that leaving the community was difficult because of the meaningful connections formed.

Learning and Skill Development

Personal growth

The remoteness, combined with the cultural differences, was a new experience for almost all the students and provided an opportunity for both personal and professional growth. The students reported learning to think beyond protocols and guidelines and to adapt practice to the context. Learning to self-reflect and engage in peer supervision to consolidate learning:

> It definitely was quite stressful the first couple of weeks… I've had to really critically consider every one of my interactions and really work through like 'what did I do well? What did I do not so well?' but I feel like I'm able to do both, like acknowledge my good and my weaknesses and work through that. (N12)

The harsh climate and demanding outdoor environment also impacted student stamina and ability to maximise learning:

> I wasn't used to the heat…I would get really sleepy after lunchtime, and I think it's a bit of dehydration. Usually I could last the day in a clinical setting where it's air-conditioned, you don't have to walk as much. But here physios are always out in the sun walking even during the middle of the day. (N11)

Students recognised that the workforce model, which placed student involvement as essential to the service capacity, differed from their other placement experiences. The centrality of the student workforce was seen to upskill students rapidly in trans-disciplinary roles such as time management, communication, rapport building, decision making and autonomy in service

delivery. Students reported that this placement was ideal to learn and build skills, reducing anxiety around how they would transition from student to professional on graduation:

> So I sort of came into this not really knowing what I was doing. But I'm leaving here sort of like, I'm ready for this. (Q13)

Despite the critical focus on relationship skill development, the students also discovered that their technical skills developed. Students reported developing confidence and skills in clinical reasoning, describing why they were doing what they were doing:

> I really feel like my clinical reasoning developed … identifying a need and be able to clinically reason 'this is why my intervention is going to address this need'. (Q9)

Learner burden

Almost all participants repeatedly discussed the learner burden for students. Students were also mostly new to remote and First Nations community life and were working in a unique and new service model. This combination put pressure on the capability and capacity of the service:

> I felt I was prepared for it, but …it took quite a lot for me to adjust… I think it was being away from home because it's my first placement away from home, adjusting to the rural setting. Then also, it was a different sort of practice area than I'd done before. So all of those three things made it a little more difficult for me. (Q12)

Interprofessional practice

Learning from students and clinical supervisors who may be from a different allied health discipline was valued. Students who were able to work in an interprofessional team with students from another discipline were able to reflect on the value of this both for their knowledge but also for clients:

> One client wanted to throw a cast net and I could break down that goal, but I wanted to also incorporate some balance and lower limb stuff. So the physios were able to work on that while I made it tailored to the fishing. (Q12)

Patient-centred practice

The model through which students had to deliver services challenged their knowledge about delivering evidence-based practice based on impairment models. Students commented on the complexity and variety of the clinical practice:

> It's very difficult, …but there are other conditions that they had with [primary condition]… So like, if you're looking at evidence based practice, and you know, it was for that condition, but [if health professionals] didn't consider, every other condition that they had, I'd find it very difficult to implement that [evidence]. And then kind of think about everything else that goes with it. (Q14)

Students had to be responsive in their clinical practice, responding to patient need first and not clinical or therapy goals:"I feel like it's more about you and the person, and what you're going to offer for this person rather than just physio" *(N5).* Some students gave examples of how they developed a trusting relationship over an extended period that supported focusing on the person's functional and contextual needs rather than immediately assessing and developing a deficit-based management plan.

Culturally Responsive Practice

Finally, the IAHA framework (2019) identifies the capabilities needed to provide culturally responsive services. The students working in the service-learning placements articulated aspects of these capabilities in ways that supported our assertion that the service and the professionals employed in the service were developing capabilities aligned with being culturally responsive. Table 2 provides evidence to support the contention that the service-learning placement model allows students the opportunity to build external relationships and potentially influence cultural change in health services.

Table 2

Summary of the Experiences Reported by Participants, Coded Against the Capabilities in the Culturally Responsiveness in Action Framework (2019)

Capability	Students reported this by:
Respect for the centrality of cultures	Learning about culture through opportunities offered. Showed respect by applying learning to service provision approaches.
Self-awareness	Actively engaged with cultural educators, community members who shared knowledge, and skilled health professionals who guided their learning and reflections. Modified their actions because of insights gained.
Proactivity	Listened to and asked questions of supervisors and cultural educators; challenged each other when debriefing together in order to adapt practices appropriately
Inclusive engagement	Prioritised relationships over clinical service delivery, seeking to adapt Western health management knowledge to the expressed needs of service users. Offered services in locations selected by service users.
Leadership	It was recognised that their understanding of First Nations health will influence their interactions in other settings. Students saw the First Nations staff and community members as leaders in the design of the service.
Responsibility and accountability	Reflected on what they had understood prior to the placement and how their understandings had grown over the placement. Demonstrated awareness of the need to apply their learning into other settings.

Discussion

Remote communities in Australia need a health workforce that is prepared for the experience of remote life and ready to work in a culturally responsive way, closely connected to the daily experiences of community members. Introducing allied health students to the concepts of a remote (rural) generalist workload (interprofessional, culturally responsive and community integrated) is essential to prepare the future health workforce for the challenges and advantages of working in remote northern Australia. Aligned with prior research, the service-learning placement experience, as described by the students, supported their readiness for work, particularly rural work (Jones et al., 2015; Longman et al., 2020). In addition, students reported unique opportunities for personal growth, particularly relating to developing skills that support culturally responsive practice.

Learning culturally responsive practice skills was reflected in the students' experience. Mezirow (2000) describes ten steps to transformational learning that include the processes students in this study reported, from disorientation and self-examination to building competence and self-confidence in new roles and relationships. In this study, students reported initially attempting to fit a Westernised structure of healthcare delivery onto First Nations communities and having to shift their frame of reference. The introduction of new knowledge through cultural mentorship and immersion in the communities highlighted for many students the discrepancies between their existing beliefs of how health “should” be delivered and what was required to provide culturally safe services. The culture shock, reported by many students, likely occurred because the placement challenged their worldviews. Students reported the clinical practice and model of care to be very different from what they had learned from their university education or in previous placements. As a result, many students experienced the disorientation and accompanying cognitive load with ‘unlearning’ service models that are western in their philosophy and implementation.

The key mechanism for transformation appeared to be the cultural immersion that these placements afforded where students had time to learn language, build reciprocal relationships with community members, clients, family members and cultural mentors, and try new professional skills such as roles in community development and health promotion. Although the impact of length of placement was not examined in this study, it is likely that the greater the placement length, the more time students have to engage in the transformational process that supports cultural responsiveness, as it is as much a personal journey as a professional one.

Preparing for and supporting students on the personal journey to acquire culturally responsive practice skills is challenging for any placement supervisor or coordinator. A student’s ability to apply the information given before placement remains an ongoing challenge for placements where cultural immersion is required. What became evident from this study was that the minimal cultural awareness training students had completed as part of their standard university training before placement was nowhere near sufficient for them to feel prepared for a placement based in a remote First Nations community. The orientation

and ongoing support and guidance that is local and contextualised were essential in this study. Prior studies into course-based First Nations studies have also highlighted the importance of an educator in working through complex affective responses from students like embarrassment, shame and guilt as students develop an understanding of the ongoing impact of colonisation and subsequently develop greater self-awareness of their beliefs (Bullen & Roberts, 2019).

Students in our study appeared more reluctant to admit they were struggling with some cultural aspects of the placement experience, reporting it was a relief to hear others were also struggling. This reflection indicates that students are expected to be clinical learners but don't always recognise that they are active learners of First Nations culture. Future service-learning placements that target culturally responsive practice skills must consider what cultural training and support must be embedded into the supervisory teams. The clinical educator is unlikely the most appropriate person for students to recognise and explore challenging feelings about culture and race. Employing cultural educators who can provide cultural training and mentorship is essential for delivering service-learning placements that are culturally safe for both clients and students (Barker et al., 2022). The opportunity to be immersed in the culture and supported by cultural experts in the community positively impacted students. However, their role in supporting transformational learning was not explicit. The power imbalance between students and clinical educators, who also assess the students' performance, must be considered when resourcing these placements.

Lastly, students reported several other positive experiences that were well aligned with what is already known in the literature regarding the impact of service-learning placement on developing work-readiness skills and interprofessional collaboration (Prestes Vargas et al., 2024). However, students also reported challenges that are less well understood such as the impact of the physical environment on students' mood and ability to attend during placement cognitively. This, coupled with the learner burden of both clinical and cultural knowledge, appeared to impact students' perceived productivity. Appropriate provision of pastoral care and positive rural immersion experiences may help overcome this. Previous studies report attention to student well-being, thorough orientation, setting appropriate expectations and providing ongoing support from various sources can all ameliorate these risks (Green et al., 2022). Future research could consider if a relationship exists between the length of placement, quality of cultural and pastoral support, student outcomes and community experience, potentially moderated by student personality and background. Recommendations for future placements would include lengths of no less than eight weeks and/or back-to-back placement opportunities within similar geographical areas to allow students time to adapt to the physical and cultural environment.

Limitations

Students were drawn from just two remote sites in northern Australia. Students undertaking service-learning placements in other remote communities may have different experiences. It is also possible that the students felt that they had to describe a positive experience, but they did also report aspects of their placements that were more challenging. This current study interviewed students at the end of their placement and did not explore experiences during placement where students may have been more connected to their affective reactions to cultural learning in the early weeks of placement. This may have provided a more detailed analysis of the stages of transformational learning. Despite efforts to provide supportive environments, it is possible that students may not have felt culturally safe to express feelings of uncomfortableness. Additionally, some students had previously experienced other rural and remote placements or had lived in rural and remote communities, so these students may have been better prepared for the geographical context. However, it is unknown if they would be better prepared for the cultural context.

Conclusion

There were many personal and professional benefits for students undertaking service-learning placements in remote First Nations communities. The development of culturally responsive practice skills is poorly understood; however, the experience of immersive service-learning placements in remote First Nations communities appears to support the transformation learning process required to build knowledge, confidence and skills to engage in culturally responsive practice. Key elements that support students to engage with culturally responsive learning are time to build relationships, community and cultural immersion and having First Nations leadership built into the program through cultural mentorship and supervision. More research is required to understand how to best prepare students for the many unique and challenging aspects of these placement experiences and what lasting impacts this experience has on future practice.

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