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Roma Forbes
The University of Queensland

Alana Dinsdale
The University of Queensland

Jodie Copley
The University of Queensland

Jodie Booth
The University of Queensland

Daniella Cain
The University of Queensland

Meagan Crabb
The University of Queensland

Ruth Dunwoodie
The University of Queensland

Lucy Hunter
The University of Queensland

Auriel Sher
The University of Queensland

Anne Hill
The University of Queensland

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Roma Forbes[*], Alana Dinsdale[*], Jodie Copley[*], Jodie Booth[*], Daniella Cain[*], Meagan Crabb[+], Ruth Dunwoodie[*], Lucy Hunter[*], Auriel Sher[*], Anne Hill[*]

[*] School of Health and Rehabilitation Sciences, The University of Queensland, Brisbane, Australia
[+] School of Human Movement and Nutrition Sciences, The University of Queensland, Brisbane, Australia

Abstract

Background: Allied health graduates are increasingly employed in private practice settings despite limited placement opportunities during training. Understanding the benefits and barriers of hosting allied health student placements is an important step in supporting initiatives to expand clinical placement capacity within this sector.

Aims: This study aimed to explore the benefits and barriers of hosting allied health students within private practice organisations from the perspective of practices who currently, have previously, and who have never hosted students and university clinical education coordinators.

Methods: A thematic analytical approach was applied to interview data (private practices n=26) and focus group data (clinical education coordinators n=13) and a thematic network tool was used to determine common themes.

Results: Three overarching themes were generated: 1) Local and wider perceived value of placements, 2) Challenges and concerns, and 3) Weighing up.

Conclusion: The findings of this study have highlighted a range of benefits and challenges of hosting students that are carefully weighed up by practices within allied health professions. The perceived benefits to the practice and staff, as well as the wider professions are weighed up against the required resources of time, physical spaces and opportunities for students to participate in client care.

I INTRODUCTION

Allied health education providers rely on supervised clinical placements for student training to integrate the knowledge, skills and professional behaviours required for entry level practice (Hecimovich & Votel, 2011; Rodger et al., 2011; Shields et al., 2013). A significant proportion of allied health clinical placements in Australia occur in the hospital sector, particularly in large tertiary public and private hospitals. Reliance on the hospital sector for quality clinical placements has become increasingly unsustainable due to a rising number of university programs and student enrolments (Lincoln, 2012; Speech Pathology Australia, 2014; Peiris et al., 2019), necessitating the sourcing of placements across other healthcare settings including private practice.

Simultaneously, contemporary changes to healthcare delivery have led to substantial growth in the allied health private practice sector, with increased community demand, the introduction of private and government healthcare funding schemes and increasing privatisation of healthcare (Forbes et al., 2020a; Rodger et al., 2008; Sokkar et al., 2019). The significant growth of allied health private practice services in Australia, however, has not been followed by a relative rise in the number of private practices offering student placements (Sokkar et al., 2019; Wells et al., 2021). Indeed, while new graduates are expected to be able to work within private practices upon graduation, many report having no placement experience in this area (Atkinson & McElroy, 2016; Peiris et al., 2019; Queensland Government, 2007). A study by Sokkar and colleagues (2015) reported that only 3% of speech pathology students at a single university were allocated to private practice paediatric placements with no placements offered in private practices supporting adult clients. Similarly, reports suggest that less than 10% of Australian physiotherapy clinical placements occur within private practice settings and less than half of all physiotherapy students undertake a full-time placement within a private practice (Peiris et al., 2019). The current lack of private practice placement opportunities may have significant implications for both the sustainability of placement opportunities and the workforce readiness of new graduate allied health professionals (Forbes et al., 2020a,b; Sealey et al., 2015; Shields et al., 2013; Sokkar et al., 2019).

There are a number of reported benefits associated with providing student placements across allied health settings including opportunities to recruit and employ graduates, thus mitigating significant recruitment time and cost (Bowles et al., 2014; Forbes et al., 2020a; Rodger et al., 2008). Other motivations include benefiting from clinical knowledge and research that students provide (Bowles et al., 2014; Davies et al., 2011; Forbes et al., 2020a; Hall et al., 2015; Rodger et al., 2008) and satisfaction related to teaching and a sense of contributing to the profession (Bowles et al., 2014; Forbes et al., 2020a; Hall et al., 2015). Contrary to some reports, practices and clinicians have reported that productivity, client care, and client satisfaction have remained unaffected, or even improved, as a result of hosting pre-registration students (Doubt et al., 2004; Forbes et al., 2020a; Forbes et al., 2021; MacPhail et al., 2011; Sloggett et al., 2003; Sokkar & McAllister, 2015).

Despite these perceived benefits, there remain numerous actual and perceived barriers to including students in private practice services and settings. Existing restrictions or changes to government funding schemes and policy may limit placement opportunities where students are excluded from service delivery (Forbes et al., 2020a; Kent et al., 2015; Speech Pathology Australia, 2014). Similarly, uncertainty and variation in interpreting third-party policies has been reported to inhibit the contribution of the private practice sector to clinical education (Doubt et al., 2004; Sloggett et al., 2003; Sokkar & McAllister, 2015). Other reported barriers include perceived negative effects on patient satisfaction, administrative and educational time costs, and impacts on existing staff on top of their caseloads, administration, and business management tasks (Forbes et al., 2020a; Hall et al., 2015; MacPhail et al., 2011; Recker-Hughes et al., 2014; Rodger et al., 2008). A lack of perceived efficiency in service delivery may also impact the service-delivery time and thus income of the supervising clinician and host organisation (Hall et al., 2015).

Despite this existing research, the perspective of private practice host organisations and those supporting student placements is limited. Further understanding of the perceived benefits and

barriers to hosting students from both managers of private practices and education providers, or universities, is important to understand what motivates private practices to engage in clinical education and inform how practices can be best supported in student supervision. In addition, there has been no research to date that has explored the perceived benefits and challenges of hosting students from the perspective of allied health practices that no longer, or have never, hosted students. An understanding of this perspective will allow education providers and the professions to address reluctance in offering student placements and how hosting students can be promoted to new or existing practices. Therefore, the aim of this study was to explore the perceived benefits and barriers to hosting allied health student placements from the perspective of private practices who currently, have previously, and who have never hosted students as well as the perspective of university clinical education coordinators.

II METHODS

A thematic analytical approach (Braun & Clarke, 2006) with a subsequent thematic network tool (Attride-Stirling, 2001) was used to identify and establish consensus on commonality of themes across participant groups. Triangulation of relevant and informed stakeholder groups was chosen to allow exploration of perspectives using a variety of methods to offer a more balanced explanation (Noble & Heale, 2019). Semi-structured interviews and focus groups were employed to facilitate open, authentic discussions of the phenomenon, allowing participants to express their views freely in their own terms (Cohen & Crabtree, 2006). This study was approved by The University of Queensland – Institutional Human Research Ethics, approval number #202002067. Reporting has observed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.

A *Participants*

Clinical education hosts from private practices across five allied health professions (physiotherapy, occupational therapy, audiology, speech pathology, exercise physiology) were recruited. Purposeful sampling was undertaken to ensure representation of a range of Australian allied health professions with high proportions of services delivered in private practice settings. Practices were comprised of three groups; those who: i) currently host full-time student placements from The University of Queensland; ii) have previously hosted full-time students from The University of Queensland but no longer host, or iii) have never hosted full-time student placements. Inclusion criteria for practices currently hosting students were that at least one student had been hosted within the previous 24 months and that staff could provide insight into how students are hosted and contribute to service delivery within the practice. Previous hosts must have hosted at least one student within the previous 5 years and non-hosts must have not hosted a full-time clinical placement. Interview participants from each practice were required to be practice representatives (owners or managers), involved in clinical education, and able to provide insight into decision making about hosting students (Rubin & Rubin, 2011).

Australian university-based clinical education coordination staff, who were professional contacts of the research team, were purposively recruited. These participants were invited from universities across Australia, to ensure that a wide range of perspectives could be sought outside of the research team. Inclusion criteria specified that clinical education staff had been directly involved in clinical education support for allied health private practice hosts for at least 6 months within one or more included professions, and this experience had been within the previous 24 months to allow for sufficient recall. For the purposes of the manuscript, these participants are referred to herein as “clinical education coordinators”.

B *Recruitment*

Email contacts for potential participating practices were accessed from The University of Queensland clinical education database of all current and previous clinical education hosts of the included five professions. Emails were sent to each health professional group in rounds of up to

20. This initial email aimed to outline the study, determine eligibility and arrange a mutually acceptable time for interviewing. Further emails were sent in four subsequent rounds when insufficient responses had been received within seven days. A total of 93 emails were sent from the lead researcher (RF) to current (n=43), previous (n=33) and known practices who have never hosted full-time student placements (n=17). Thirty-two practices (response rate 34%) responded to the initial email and indicated interest. Of these, 31 met inclusion criteria. Twenty-nine respondents were then purposively selected to reflect a range of professions and host types. Twenty-six respondents provided written consent for interviewing. All remaining potential participants were informed via email that participation was no longer required.

A total of 48 emails were sent to clinical education coordinator contacts of the research team who represented each of the allied health professions, inviting them to reply to the lead researcher. Sixteen clinical education coordinators responded via email (response rate 29%). A web-based poll was used to select four potential times for focus groups over a two-week period (March-April, 2021). Thirteen participants indicated availability and provided written consent to participate.

C *Procedure*

The draft interview (private practices) and focus group (clinical education coordinators) frameworks were developed by the research team based on a review of the literature and consultation with a stakeholder group that included one private practice provider, two clinical educators and one clinical education coordinator. The interview framework underwent piloting with an additional cohort of two private practice providers and two clinical educators not involved within the study to ensure clarity and familiarisation (Minichiello et al., 2008) (Figure 1).

Figure 1.
Example interview questions

Can you tell me about what factors you considered when deciding to host students within your own practice?
What were your expectations of providing student placements?
Was/would the potential impact on clients considered? What do/did you think these impacts might be?
What do you/did you think might be the potential impact on your practice? And staff?
What do you feel are the benefits to hosting students?
Do benefits extend beyond service delivery, and how? (where relevant)
Are there barriers to hosting students? What are they? How do they affect your practice?
Are there costs involved?
How do you overcome these challenges or barriers?
Is your decision to host an ongoing commitment to students, or do you revise it based on other factors?

Interviews were conducted by the lead researcher, experienced in qualitative interviewing and clinical education, via telephone and audio recorded. All data were transcribed through a professional transcription service and de-identified by the lead researcher prior to analysis. Data collection and analysis occurred concurrently from November 2020 until March 2021. Interviews were a mean of 38 minutes (18–59 minutes) in duration.

All focus groups were conducted by the lead researcher (RF) and recorded using the platform Zoom (Zoom Video Communications Inc, 2020). The focus groups were designed to encourage discussion between group members to enhance data quality, reveal new topics, and provide balance to false or extreme views (Patton, 2002). Example questions are outlined in Figure 2. Zoom has been identified as a viable method for qualitative data collection, as it provides an easy to use, cost-effective and secure method of engagement (Archibald et al., 2019). Focus groups were 46, 52, 47 and 29 minutes in duration, respectively.

Figure 2.
Example focus group questions

What is unique about private practice? What makes their needs different to other hosts?
What are some of the reasons that you are aware of that lead private practice settings to choose to host students? (including clarifying questions)
Are there particular areas of apprehension from potential sites?
How do practices navigate decision making, from your perspective?
Can you tell me about experiences that you have had where private practice sites have integrated students effectively for excellent student learning experiences?
What do you think would help future, current or previous private practice placement sites to integrate students more successfully in a way that benefits the practice and its staff?

D *Data analysis*

Thematic analysis followed Braun and Clarke's (2006) analytical framework, which began with familiarisation of interview data and categorisation into an initial coding framework. This coding framework was then applied to the analysis of focus group data with the opportunity of the modification and addition of new codes. Similar codes were grouped into subcategories using a step-wise process involving comparison, reflection, and interpretation of codes and categories. Codes were gathered into subthemes, which were further integrated into overarching themes if commonalities or interrelationships were recognized. The candidate themes and subthemes were subjected to continuous comparison and differentiation to ensure appropriate categorisation and eventual consensus between the two lead authors (RF, AD) and then two additional authors (AH, JC).

A thematic network tool was used to identify and establish consensus of themes across participant groups by the lead researcher (RF) (Attride-Stirling, 2001). A thematic network assists the thematic analysis process through organising qualitative data and facilitating "structuring and depicting of these themes" (Attride-Stirling, 2001, p. 387). This included grouping of themes, with concurrent and relevant subthemes reflecting ideas from individual, multiple, or all participant groups. These were further organised into overarching themes that were able to summarise the overall data (Attride-Stirling, 2001). This process was repeated independently by the second lead researcher (AD), with members of the research team (RF, AD, AH, JC) meeting to allow discussion and agreement on final themes across participant groups. Separate analytical procedures were followed for data from interviews with private practice hosts and focus group data from clinical education coordinators, with the exception of the coding framework, to enable a focus on similarities and differences across participant groups. These were then compared to identify tensions within and across participant groups, and to enhance reflexivity. Data saturation was intended and achieved, where no new information or themes were identified from data (Guest et al., 2006) which was determined by the research team at analysis of 25 interview transcripts and data from five focus groups.

The authors focused on steps to promote qualitative rigour through credibility, dependability, and transferability. To maintain credibility, all processes of analysis of codes, subcategories and themes were undertaken independently by two researchers (RF, AD) and these steps were then reviewed by members of the wider research team including debriefing and reviewing of coding. Member checking of interview data was performed by returning transcriptions to all interview participants, with no significant alterations made. Dependability was achieved through ensuring procedures for data analysis were performed independently by more than one researcher (RF, AD) and emergent themes were discussed amongst the research team who included academics, clinical educators and clinical education coordinators. Utilising two participant groups and ensuring participants reflected a range of professions and perspectives enhanced transferability of the findings.

E *Reflexivity*

Rigorous qualitative research requires researcher reflexivity to consider how data interpretation may be influenced by worldviews or perspectives (Mays & Pope, 2000). The primary researcher conducting interviews and analysis had over fifteen years' experience as a private practice clinician and clinical educator and had been teaching physiotherapy students in a university setting for over five years. This may have contributed to a deeper understanding of the impact and challenges of hosting students on private practice providers, staff and service delivery and the perspective of the education provider. The second researcher who conducted all steps independently has over nine years' experience in private practice and experience in clinical education within these settings. To mitigate concerns that these previous experiences would introduce significant bias, the research team employed several strategies to enhance trustworthiness. The interviewers had no relationship with the practice providers and were not involved in providing or managing student placements. The researchers engaged in regular review meetings throughout and following data collection to identify and discuss potential biases and assumptions which included identifying the experience of the research team which is primarily within education outside of the private practice sector.

III RESULTS

Current host practices had been hosting allied health students for between one and 19 years (median 5, IQR 3-10). Six practices had experience of hosting multiple physiotherapy students within the same placement period. Further private practice demographic data are outlined in Table 1.

Table 1.
Private practice participant demographic information

Participant	Host status	Profession	Location	Number of sites hosting students	Years hosting	Multiple students	Students/ year	Supervision ratio (Staff: student)
1	Current	A	M	2	6	No	7	1:1
2	Current	A	M	6	14	No	8	1:1
3	Current	EP	M	1	10	Yes	12	7:3
4	Current	EP	M & R	2	4	No	2	2:1
5	Current	EP	M	1	2	Yes	1-2	2:1
6	Current	EP/OT/PT	M	1	5/3/12	Yes	6/6/10	1:1
7	Current	OT	M	2	8	Yes	8	3-4:2
8	Current	OT	M	13	2.5	No	1	2:1
9	Current	OT	R	1	12	No	3	1:1
10	Current	OT	M	1	3	No	4	2:1
11	Current	PT	M	1	5	Yes	8	2:2
12	Current	PT	M	1	2	No	3	4:1
13	Current	PT	M	1	10	Yes	4	2:1
14	Current	PT	R	1	2	No	4	1:1
15	Current	PT	M	1	1	No	4	2:1
16	Current	PT	R	1	4	No	6	1:1
17	Current	PT	M	1	19	No	3	3:1
18	Current	SP	R	1	4	No	1	2:1
19	Current	SP	M	2	1	No	2	1:1
20	Previous	EP/PT	M	1	11/4	No	NA	NA
21	Previous	PT	M	1	5	No	NA	NA
22	Previous	PT	M	1	5	No	NA	NA

Participant	Host status	Profession	Location	Number of sites hosting students	Years hosting	Multiple students	Students/ year	Supervision ratio (Staff: student)
23	Non	OT	M	1	NA	NA	NA	NA
24	Non	OT	M	1	NA	NA	NA	NA
25	Non	PT	M	1	NA	NA	NA	NA
26	Non	PT	M	1	NA	NA	NA	NA

A – Audiology, EP –Exercise physiology, OT – Occupational Therapy, PT – Physiotherapy, M – Metropolitan, R – Regional or Rural, NA – not applicable

Clinical education coordinators ranged in experience within a clinical education coordinator role with a university education provider from 6 months to 10 years (mean = 5.1 years). Eight coordinators were from Queensland, two from South Australia and one each from Victoria, New South Wales and the Australian Capital Territory. Further demographic data is outlined in Table 2.

Table 2.
University clinical education coordinator demographic information

	Focus group 1	Focus group 2	Focus group 3	Focus group 4
Participant # Profession Experience	Participant 1 (FG1P1) Physiotherapy 1 year	Participant 1 (FG2P1) Physiotherapy 5 years	Participant 1 (FG3P1) Physiotherapy 8 years	Participant 1 (FG4P1) Speech Pathology 2 years
Participant # Profession Experience	Participant 2 (FG1P2) Exercise Physiology 6 months	Participant 2 (FG2P2) Occupational Therapy 6 years	Participant 2 (FG3P2) Occupational Therapy 7 years	Participant 2 (FG4P2) Speech Pathology 10 years
Participant # Profession Experience	Participant 3 (FG1P3) Occupational Therapy 6 years	Participant 3 (FG2P3) Exercise Physiology 7 years	Participant 3 (FG3P3) Physiotherapy 2.5 years	
Participant # Profession Experience		Participant 4 (FG2P4) Exercise Physiology 2 years	Participant 4 (FG3P4) Physiotherapy 9.5 years	

Analysis of data generated three themes, each with two subthemes, reflecting benefits and challenges of hosting student placements from the perspectives of private practice participants and clinical education coordinators. Additional example quotes supporting each theme and subtheme are outlined in Appendix 1.

A *Theme 1: Local and wider perceived value of placements*

1 *Subtheme: Benefits for recruitment*

Potential for recruitment of future clinical staff was a major driver for practices to initiate and continue hosting students. Hosting students was viewed as an opportunity to ‘try before we buy’ (P15) or a ‘5-week interview’ (FG3P3) whereby host practices were able to assess suitability and fit of students as future employees.

> P13: This is a good opportunity for us to really see what new grads are like; to know what supports they need and what they can offer, for when we or others may take them on in the future

FGP1: There definitely is discussion around recruitment, particularly for (final) year students, thinking that if they take students on, then there's the opportunity for the student to them carry on as a practitioner afterwards within the placement

These benefits were particularly apparent for those in rural settings where recruitment was viewed as more challenging. Participants expressed that students would be more likely to apply for rurally based positions if they could experience firsthand the '*networks and supports and setup'* (P18) of rural private practices.

P18: A lot of new graduates don't want to come out to a rural area as a new graduate. One reason why I fight so hard to try and get students out here, is that they can see what working in a rural setting is like

2 *Subtheme: Benefits to the staff and practice*

Current host participants had a strong perception of benefits for staff involved in hosting students and for the wider practice, especially recognition of the knowledge, skills, and enhancements in clinical reasoning that students provided. This often related to *'further education opportunities'* (P3) for staff where clinical reasoning was a focus of skill development that students contributed to.

P4: Having a student come in and go, "Why do you do that?" You go, hey, why do I do that? It really keeps our clinical reasoning sharp

FG1P2: Students are coming in with these new evidence-based protocols and things they've learnt. So it really helps keep their staff abreast of the current research and literature

These benefits were not only immediate but also related to long-term strategies to aid staff, practice, and client service development.

P10: (Hosting students) is nice for us to sit back and review what we were doing and actually verbalising - and go through some of those processes that become so automatic and therefore better over time

FG2P2: (Placements) creates opportunities for (practices) to have students explore research areas that the business is wanting to gather a greater evidence base for, or develop new systems of frameworks around particular populations

The benefits to staff also extended to other areas of professional life such as providing *'other challenges and opportunities'* when staff members are *'hitting a ceiling'* (FG3P3). This also extended to professional and personal satisfaction from hosting students. Participants felt that being involved in hosting students and their education, was ultimately personally fulfilling and rewarding.

P1: Audiology can be a very lonely profession, you can be in a room by yourself, so my colleague who is the new grad, she said that she loves it because it's another person that she's talking with

P19: There is something really lovely about being involved in the development and mentoring of our next generation of therapists. It's really rewarding, and that's a big driver for why we do it

FG3P2: Sometimes the positive energy and the positive enthusiasm that a student brings can lift the morale of a private practice if they're feeling a bit burnt out or a bit tired

Benefits for the practice and its staff also extended to the practical skills and assistance that students could provide. There was a strong sense that having an *'extra pair of hands'* (P4, P8, P19) or *'two pairs of eyes'* (FG1P2) was helpful within the practice and its operation. These benefits also extended to non-client contact related activities that students were able to participate in or complete that contributed to the overall practice, particularly activities including *'research and literature reviewing'* that staff '*don't have time to do'* (P8)

P8: Our group (classes) could be led by the student with their (supervisor) there. Rather than using our allied health assistants or another physio where you can only charge one person's time, students can be running groups

FG3P2: We've got students contributing with quality improvement, writing programs, research, assisting with organisations to implement real research but it is actually practice education at the same time because they're interviewing people, they're gathering data, doing assessments and things like that as well

3 *Subtheme: Passion for the profession*

Current hosts and clinical education coordinators reflected on a passion to support their current and future profession as a driver to host students, especially developing the private practice sector workforce and sharing career opportunities in this setting.

> P10: We want to see our profession grow and develop and be the best (it) can. So, by providing opportunities – it can reflect what is happening in the real world

> FG3P4: I want students to have exposure to …the business realities of owning a practice, the efficiencies that clinicians use. … (With this) higher pace and higher client load there is a bit more breadth of exposure to different clinical presentations and communication styles

This expressed 'need' for students to be exposed to private practice also extended to those no longer, or not hosting students and clinical education coordinators.

> P20: We've got to be able to expose (students) to private practice. We have more therapists in private practice so we're going to need to be able to host them somehow

> FG2P4: There needs to be support at a higher level, at a national level, and from an advocacy level from our peak bodies, and from government as well, to acknowledge the work that students do in this industry

B *Theme 2: Challenges and concerns*

1 *Subtheme: Resource stressors*

The overarching challenge recognised by participant groups was the stressors associated with hosting students. Resource costs predominantly related to time as the *'primary concern'* (FGP3) and physical spaces but also extended in some cases to ensuring access to appropriate clientele for clinical learning experiences.

> P4: In the weeks where we have students, I'm probably in the clinic an extra two to three hours a week just backpedalling

> P11: Just trying to make sure that we're getting consistency of patients for them as well is probably one of the big challenges

Some participants felt that time costs would be more of an issue for smaller practices, potentially acting a significant barrier to hosting students.

> P19: We can absorb (students) because we're big enough, but I can certainly understand why other small practices are disincentivised

> FG1P2: Certainly, in our field, the private practices are inevitably manned by a much smaller taskforce than at the larger organisations. So, the teaching and mentorship burden per person is a lot heavier on the staff

Participants who have never hosted students strongly recognised time stressors and costs as a major barrier for hosting. This time cost was often weighed up against the benefits of hosting a student. However, concerns about the financial impact to the practice tended to only be recognised by those who did not host students.

> P20: I'm busy, my time is precious, I'm selfish with my weekends. Why would I be inclined to put myself through that when maybe I can find other ways of contributing to the profession?

> P24: It's billable hours, so as a therapist if I'm billing. If it takes me an extra half an hour in explaining things to the student, I can't bill that stuff

> FG2P4: When I talk to private practices (who have not hosted placements) they say the same things, "We're too busy" "We need funding" "We haven't got time."

Access to physical spaces was a major limiting factor that was considered by participants, especially those who discontinued hosting placements or those who have never hosted.

> P21: And I could do it at other places but in our practice, we've only got two rooms and it's just impossible really

FG4P2: Physical space is a boundary, because a lot of these private practices work out of small spaces. And that was a problem before COVID distancing came along. So, I think the logistics of access to resources, tech, physical space, I think is also often more problematic in a private setting

2 *Subtheme: Funding and medicolegal concerns for service delivery*

Current host participants were challenged about how to manage billing and funding when students were contributing to clinical services. This was often considered when deciding whether to host students.

P8: It's a bit grey between charging for time to the NDIS model, if the student develops the resources for the client. Do we charge for that? Do we not charge for that? Just trying to understand where that lies which I don't think we had a clear picture of it yet

FG3P2: (Not understanding billing) is preventing organisations from offering student placements… because the legislation isn't clear around how students need to be supported in that space

Participants that do not host students had ongoing concerns about the impact that students may have on their current service provision and associated funding.

P24: NDIS is always changing every five minutes it seems or depending on who your coordinator, or planner or whoever is so we just don't know

FG2P4: One of the biggest barriers that I hear in the private industry comes down to billing. I had a chat just now with a private practice, who are looking at taking our students, and then they said, okay, "So can we bill for Medicare, can we bill for Workcover," for when the students get involved

C *Theme 3: Weighing up*

1 *Subtheme 1: Weighing up the impact on the client.*

Participants strongly weighed up the impact on the client and their expectations when students were involved. Several practices were able to recognise direct client benefits such as *'more frequent interventions'* (P9) which were weighed up against the costs or challenges of hosting students. There was however a strong perception of the need for active and close supervision to ensure optimal client care was maintained.

P9: For example, I would only be able to see (the client) once a fortnight at best. But while the students are in placement, they have been able to have weekly therapy

P21: It just wasn't possible while working full time to supervise adequately. You need that to be one on one, you can't just leave them

Consideration of the client perspective for both perceived service quality and 'value for money' was a major reason why some practices chose not to host students or to no longer host students. This also related to managing the perceived reputation of the practice.

P21: We get a lot of people that have been to other practices that have failed in their (therapy). They weren't happy or they didn't get better and then they've been referred to us. So, if they then get a student, they wouldn't be happy because they want the experience or the extra qualification

P26: We spend a lot of time marketing and getting the client happy to return. You can't just really have someone who's not qualified to treat your client base. People are paying a lot of money to see us and they don't want to see a student

FG3P4: The client being a customer is one that we often are in discussion with our practice partners about…some perceive students services as a lesser service as we all know

2 *Subtheme: Weighing up of benefits and challenges for the practice.*

Participants reflected on a cyclical approach of weighing up the challenges of hosting students, especially on staff, with the benefits. This tended to be an ongoing process, often occurring when weighing up capacity *'at the time'* (P2), rather than a permanent decision.

P2: There have been occasions where the clinicians just are not ready or not prepared to take on students due to their own workload, so we really need to respect that. They'll say, "I just can't do it this year" and that's ok

FG2P1: I think there are certainly (ongoing concerns about) the pressure on priority to their clients, the billable hours, and weighing up the time that they can dedicate to student education and supervision

Participants who had not hosted students were challenged with this concept of weighing up and perceived a lack of flexibility in hosting students as a major and ongoing barrier.

P24: I had thought of trying to do – if I could navigate – like pairing with another private practice, then we can share the load of the one student between two practices and stuff, but I think logistically unless the University facilitates that, it gets a bit hard for the part time practitioner

FG3P4: The challenge is that they want them part-time two or three mornings a week and it can be a bit of patch-working to put together a meaningful placement

IV DISCUSSION

The aim of this study was to explore the perceived benefits, challenges and decision making associated with hosting allied health student placements within private practice settings. This is the first study to explore these factors from the perspective of both current and previous placement hosts and those that have never hosted students, including the unique view of clinical education coordinators who are responsible for supporting private practice providers to initiate and sustain allied health placements. The results indicate a range of benefits and challenges of hosting students that are carefully weighed up by practices within allied health professions.

The results of the current study highlight the role of graduate recruitment as a major driver for hosting health professional students, strongly supporting existing research across health professions (Eley & Baker, 2009; Forbes et al., 2020a; Mulholland & Derdall, 2005; Rodger et al., 2011; Sloggett et al., 2003). Private practices and clinical education coordinators recognised hosting placements as both a valuable and meaningful way of appraising students in their specific workplace setting towards the end of their allied health programs, thus providing an opportunity to actively evaluate their fit within the organisation. Practices located in regional settings reflected particular challenges around recruitment, and cited hosting students as critical to attracting future employees. Hudson and colleagues (2012) similarly reported that hosting student placements was the most successful approach to recruiting new medical graduates within regional settings, mitigating considerable costs to practices (Hudson et al., 2012). The recruitment-based benefits of placements also impact students and new graduates. Where students have had positive clinical placement experiences, they may be empowered to consider employment from a position of knowledge and experience which may positively influence retention when employed (Rodger et al., 2008). This is especially relevant given that previous research in Australian health professional education has reported that clinical placements strongly influence intention to practice (Roberts et al., 2012). Given the significant cost of staff attrition and recruitment, the benefits of "investing" in clinical placements as a recruitment strategy should continue to be promoted to private practices and other organisations and employers (Buchanan et al., 2014; Forbes et al., 2020a).

A major factor in the decision-making surrounding hosting allied health students, regardless of experience hosting, related to weighing up challenges and opportunities for client care. Concerns regarding quality of care and client satisfaction reflected a strong consideration of how students would influence existing service delivery in a way that would ensure high standards of care were maintained. These perspectives were supported by clinical education coordinators who expressed opportunities for client service delivery through hosting students, yet conveyed concerns raised by current and potential private practices regarding possible impacts on clients. To maintain client care and satisfaction, private practices and coordinators recognised the requirement of high levels of supervision where students were involved. This is consistent with previous research that has indicated that with active and consistent supervision, clients are satisfied with the involvement of students, especially if supervision is maintained across the continuum of care (Davies et al., 2011; Forbes and Nolan, 2018; Sokkar et al., 2019; Vaughn et

al., 2015). Interestingly, current and previous hosts in this study recounted positive experiences of placements enabling student-delivered care and expressed fewer concerns or barriers than those who had never hosted students before. Some practices identified the value of student service provision for those clients who could no longer afford full fee-paying services, or who would benefit from additional student-delivered care during or following a consultation, as consistent with previous research in private practice physiotherapy (Forbes et al., 2020) and speech pathology (Sokkar et al., 2019) settings. This is an increasingly relevant consideration for client care, as pointed out by Sokkar and colleagues (2019), given the current challenge of meeting evidence-based therapy intervention frequency and dosage, with limited funding, staff shortages and growing waitlists for allied health services (Ruggero et al., 2012; Sokkar et al., 2019).

The results of this study reflect the careful consideration by practices regarding client service activities that are appropriate for student involvement. This is especially relevant within healthcare, where responsibility must relate to the supervision provided and the medicolegal requirements of the practice and funding provider (Gordon et al., 2000). It also reflects that client satisfaction is a paramount concern for private practices and their staff as satisfaction can impact the reputation of the practice and the business (Kauffman et al., 2010). Other strong considerations for client care extended to the perceived need to ensure appropriate clients were selected for student involvement and planning of how these clients were subsequently supervised (Forbes & Nolan, 2018; Kent et al., 2015). Despite acknowledging that not all clients were amenable to student involvement, current hosts within the study did not nominate potential client reluctance as a barrier or challenge to hosting students, which was actively identified by non-hosts. The perspective that clients would not be amenable to student involvement tended to be reputational, where the practice perceived that their reputation for clinical care and value for money may be undermined with the presence of students.

Both current host practices and clinical education coordinators felt that student involvement in client services could contribute to the host organisation by providing practical support which allowed clinicians to extend their service capacity within and between client consultations with students involved (Forbes et al., 2020a). Of interest, previous and non-hosts did not identify potential benefits to client care or flexibility in service provision as current hosts did, rather citing more pragmatic reasons for not hosting such as limited physical spaces and staff capacity to supervise. It may be likely that such assumptions relating to flexibility made by those who no longer host, or have not hosted students, stem from personal experiences as students, or communication with other practices, which may have formed set impressions of appropriate placement models. The perceived barriers of space, staff and access to clients raised by non-hosts highlights a need for further research to consider where practices gain information relating to how students can be hosted, and to showcase the multiple and flexible models that can be adopted when hosting students. Regardless, the findings from the current study have highlighted potential avenues for private practices, education providers and the wider allied health professions in exploring flexible, additional, or extended services with the involvement of students, albeit with adequate time, space, and supervisory resources available. These may extend to shared models across multiple providers or models where the student can contribute to service delivery and conduct learning activities without being constrained by space, for example remote services (Salter et al., 2020) and activities or models that incorporate active observation (O'Regan et al., 2016).

Hosting allied health student placements provided practices with perceived benefits such as access to research, evidence-based practice, and often provided an impetus for enhancing clinical reasoning skills of practice staff. Furthermore, current and previous hosts and clinical education coordinators considered student placements to be a source of workload diversity and flexibility, potentially contributing to workplace satisfaction (Atkinson & McElroy, 2016; Davies et al., 2011; Sloggett et al., 2003). Some practices and coordinators described the important role of student contributions to project and service development and opportunities to develop teaching and learning activities for existing staff within the practice, outcomes reported in previous studies

(Davies et al., 2011; Forbes et al., 2020a; Hall et al., 2015; Sloggett et al., 2003). Involvement in clinical education has long been considered a key component of clinical professional roles within the community which is reflected in these findings where practices across allied health professions felt that providing private practice experiences was a professional responsibility (Forbes et al., 2020a; Gordon et al., 2000) and a way to 'give back' to the profession. Balancing this responsibility with a focus on meeting workforce needs (Bowles et al., 2014) is an important consideration for the private practice sector, education providers and the wider profession.

The findings from the current study concurred with outcomes of other research within allied health settings including physiotherapy, speech pathology and occupational therapy which have explored perceived challenges of providing student placements within private practice settings (Doubt et al., 2004; Forbes et al., 2020a; MacPhail et al., 2011; Maloney et al., 2013; Potts et al., 1998; Sloggett et al., 2003; Sokkar & McAllister, 2015; Sokkar et al., 2019). Several perceived barriers and challenges have been consistently reported, including stressors relating to time commitments, associated impacts on service delivery capacity, and legal and funding concerns (Davies et al., 2011; Forbes et al., 2020a; Kent et al., 2015). This finding is not unique to health care services, as workplaces are challenged to develop student skills within their settings when workplaces are already under increasing pressure to simply provide core services. Clinicians have previously reported that uncertainty regarding third-party funding when students are involved in service delivery remains an ongoing barrier to hosting students within their setting (Doubt et al., 2004; Sloggett et al., 2003). It will remain challenging for the allied health private practice workforce to increase its contribution to clinical education where government funding schemes and associated medicolegal policies exclude students from contributing to clinical services or where confusion around private and third-party funders remain (Forbes et al., 2020a; Speech Pathology Australia, 2014; Sokkar et al., 2019). Of interest, this was explicitly raised by clinical education coordinators as an ongoing and significant challenge, frequently raised by potential and existing hosts. Allied health professions should continue to advocate for clarity around funding for services where students are involved, and further research should consider the impact on student contribution to allied health service delivery.

Of interest, private practices that had not hosted students more openly raised concerns around potential or actual time resource and associated financial impacts, and this perspective was supported by clinical education coordinators. This may be because clinical education coordinators are in positions of negotiating placements within potential host sites who may be more active in raising concerns. Practices that have never hosted students may also have a higher perception of financial cost when there is uncertainty of how students can be integrated into service delivery. These concerns, especially from the perspective of those that do not currently host student placements, must be considered by allied health professional bodies as the significant rise in programs and student numbers will continue to be increasingly challenging for education providers to secure sufficient placements that reflect workforce needs (Forbes et al., 2020a; Lincoln, 2012). Concerns regarding potential financial costs should be actively addressed in communications and within relevant literature, especially by the wider professional bodies, including opportunities to cite research or counter with experiences where hosting students does not impact financial outcomes in allied health private practice settings (Forbes et al., 2021). Regardless, concerns relating to time commitments and the associated personal or professional stressors remain key challenges of hosting students across private practices. As the time required for teaching and administration is one of the biggest potential barriers to hosting students within private practices (Davies et al., 2011), it is important that time commitments and expectations are relayed effectively and accurately to potential host providers and that education providers work with current and potential practices to minimise the impact of placement time requirements on staff or their services. Specific strategies may include allowing flexibility in scheduling around service delivery (Peiris et al., 2019) and providing practices with resources to facilitate student orientation and additional learning or self-reflection activities (Forbes et al., 2020b; Kent et al., 2015).

A *Limitations*

This study recruited private practice hosts, previous hosts, and non-hosts from a database at a single university site which may limit generalisability of the findings to wider settings, especially outside of Australia. However, participating practices reflected a range of allied health professions, including multi-disciplinary practices, and represented a range of approaches to hosting students, thereby enabling a range of perspectives to be captured. All participants were volunteers and, therefore, are a self-selecting sample. Practices who currently host students and selected to participate may also reflect those with mostly positive experiences with hosting students. As the practice participants group was limited to those of practice managers or owners, the unique perspective of staff employed within the practice responsible for student supervision and client care may be excluded. Lastly, all participants may have been affected by response bias, given that members of the research team are involved in managing student placements. We attempted to reduce these impacts by ensuring the interviewer was not known to practice participants and that they were not involved in organising clinical placements. In addition, careful de-identification of all participants was made prior to analysis and sharing findings within the research team.

V CONCLUSION

The shift to private practice provision of allied health services has not been matched by a proportionate increase in clinical placements in these settings. This has raised concerns from education providers and allied health professions regarding placement supply and access while increasing concerns for graduate readiness for private practice workforce settings. Understanding the benefits and challenges of hosting allied health students within private practice settings from the perspective of private practices and those responsible for managing student placements provides insight into how practices weigh up whether to host students and how concerns about hosting students may be addressed. Despite stress relating to time, physical space and staffing resources emerging as the major challenges of hosting allied health students, it should be reinforced that the inclusion of students within private practice settings was often reported as a positive experience with a perception of benefits for practices, staff and their clients. A focus on partnership and shared responsibility must remain central to allied health professional bodies, education providers and the private practice sector to ensure that clinical education capacity can be sustained into the future and can better meet workforce preparation needs.

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Appendix 1

Examples of supporting quotes.

Theme	Examples of Supporting Quotes
Theme 1, subtheme 1; Benefits for recruitment	There's been occasions where we've recruited students once they've graduated. We've got two therapists now who were actually students with us from previous years (P7)
	By the end of (the student's) placement they were already almost taking on the role of the physio so they will be really well equipped, more so than someone new would (P17)
	For us, having students has been a great recruiting tool. It's the best six-week interview you'll ever get (P4)
	If you can show that there are private practices out there that have appropriate networks and supports and setup, then (students) are more likely to apply for jobs after they graduate out in rural areas and so therefore helping us with our staffing problems out here (P18)
	The try before you buy certainly comes strongly across (FG2P1)
Theme 1, subtheme 2; Benefits to the staff and practice	Hosting students helps with us being able to be more confident with clinical reasoning, explaining different things, client education and education to the students as well (P3)
	It's important that we learn how to teach, and it makes us better clinicians when we have to explain to somebody why we have to do what we do (P7)
	A lot of our emerging senior clinicians who might not quite be there yet to step up into a senior role have sort of been getting itchy feet and they want sort of that next step in their career to host students and to demonstrate they can do that (P8)
	I could name four students that I've kept in contact with, two have asked me to be referees, I've had that ongoing professional connection. I enjoy that (P1)
	We can use (students) in the background for resource development or learning to write reports for the NDIS and those sorts of skills. There's plenty of things that they can do within my practice that actually do turn into billable hours ultimately, of course, within the constraints of the funding model that they're working on (P9)
	They can offer some extra sessions that are billed especially for students…or some group programs where they get an extra person with an OT to run groups, and it helps with their ratios. So, when they can clearly identify the benefits of the student role, it works really well, and they're the ones that continually offer and have students all year round (FG2P1)
	The idea that students are evidence-based practitioners who have the most recent knowledge is constant feedback that we get from private practice saying that, potentially it saves them on professional development because they get students to run mini professional development events for their organisation while they're there (FG3P2)
	There are group sessions that are always run, and it makes it much easier for patients to have input…whether that be the student or the general clinician, if there are more people available (FG1P2)
Theme 1, subtheme 3; passion for the profession	We want to see that the therapists coming through know private practice and the work that we do – we need good skills coming into the workforce (P7)
	I really feel there are areas of audiology (cochlear implants) to be celebrated, and I wanted to give that experience (P1)
	So, for me, I would because I do love taking in students, showing them what it's like and how you apply things into actual practice, so for me it would be about giving back to the (university) and giving back to the students and allowing them to see where do they want to go as part of their career (P20)

Theme	Examples of Supporting Quotes
Theme 2, subtheme 1; resource stressors	I think, being a clinician and dealing with people all the time, in that environment, it gets quite tiring anyway and to have a student there, that can be hard (P1)
	If our clinicians are not operating at 100%, and they're operating at 50% because they have students, that's, I suppose, a barrier for us. So that's why we sort of had to wait 'til we know that our clinicians know the NDIS well (P8)
	One of our biggest barriers was space. We basically hit capacity, in terms of, the rooms I had available, and obviously making sure I had rooms for my clinicians, and also having a spare space where I could essentially sit a student when they weren't obviously doing clinical or non-clinical, or non, sort of, patient face-to-face work, was one of the biggest barriers we found (P10)
	We haven't got the most space, but we do have more than just one room. I think if you were renting a room from another clinic, or from a doctor's practice or something, that would be harder (P18)
	So I rent a room. Just say there was a situation where the client - I was seeing someone that the student was going to be prepping for another session or for some reason weren't involved in that session. I actually don't even have anywhere for them to go and do work (P20)
	The main barrier is well, we have these patients, clients that are paying x amount and they expect a certain level and we can't let students just see them and treat them as often (FG1P3)
	It's so important that (hosts) have a trust in our students, because of that element of the paying client (FG1P2)
	I think certainly the pressure on the need for priority to their clients, the billable hours, and weighing up the time that they can dedicate to student education and supervision (FG2P1)
Theme 2, subtheme 2; Funding and medicolegal concerns for service delivery	Particularly when we're working with Medicare and DVA and all those kinds of things, (I don't think) the student can actually deliver the service (P4)
	If students are seeing and doing that hands on work, how do I bill families for that? They're taking time off work, kids are taking time out of school, I guess to have a service that's not potentially as maximised in terms of what they'll get from it (P20)
	The primary one is not sure about how I would charge families for those (clinical) sessions. So trying to work out what's a fair way of doing that (P20)
Theme 3, subtheme 1; Weighing up the impact on the client	We do every now and then come against patients who say 'I'm not comfortable seeing a student'… so just trying to make sure that we are getting consistency of patients for them as well, is one of the big challenges (P16)
	I've got a lot of pretty well-established clients, and an established reputation in the area. I always give clients, parents, an opportunity to not have a student involved, but I do also create an expectation that the student will be involved in the service delivery (P9)
	It's more just when our clients are coming to see us, they're wanting to make sure they're getting the best service from us as well. As you know, in the private practice, the margins are quite small so we want to make sure that each client's definitely getting their value for money as well (P20)
	You have to expect to have people teaching and learning in the public system. But in the private system people don't — oh, I don't think tolerate that as much. They don't expect it as much (P21)
	Students want to be interacting with clients and now where we have to write reports, this has taken some of the hands-on side where the student expectations are (P24)
	(Practices) have these patients, clients that are paying x amount and they expect a certain level and (they) can't let students just see them and treat them as often (FG1P3)

Theme	Examples of Supporting Quotes
Theme 3, subtheme 2; Weighing up of benefits and challenges for the practice	We always consider the capacity of the team to support students, so we've got quite a few new guys starting with us in the new year, so we've chosen not to have students in the first term (next year) because we want to make sure that we've got enough time devoted to our new (staff) (P19)
	Time is money, and it will impact us financially, because it will reduce their caseload so that they can adequately supervise students. (Hosting students) is a decision that we need to make at a business level because you see that the benefits are worthwhile for us to do that (P7)
	For us, we manage to make up the loss of time with our recruitment of new grads and spreading the load across clinics, but in smaller practices, they may only have a few clinicians it has a big impact (P2)
	I think the biggest barrier though is not the people operating in clinical roles that are the roadblock to student placements; it's people probably like myself (management) who at the end of the day say, no, we can't do this because of the impact on finances or the impact on productivity (P8)
	But for me the biggest thing is the time and can I provide support for them? And can my other staff do that, and can we share the load so that that way it's not just one person doing all the supervision? (P20)
	I understand you need to tell the students in advance, a month, six weeks or whatever it is, but then it makes it really hard for any private practitioner to commit to anything (P24)