A model for Level I fieldwork in which students co-led independent living skills (ILS) groups in clinical settings and observed occupational therapy evaluation and treatment was implemented in a curriculum and evaluated for its effectiveness. The evaluation surveys from this study suggest that the model is most effective in courses and clinical settings that deal with adult and young adult client populations. All clinicians in these settings believed that the students provided a service to the clients by co-leading ILS groups, and nearly all believed that student-led groups would be valuable for their clients in the future. The students reported learning about group leadership skills and developing creative activity adaptations to meet different clients' needs. Faculty members want to continue using this model because they think it facilitates students' integration of clinical and classroom experiences.
Model Refinement

Survey

The faculty members were interested in expanding the model into theory courses for pediatrics, psychosocial dysfunction, and physical dysfunction. Previously in these courses, the students had been required to observe therapists in related clinical settings but not to provide client services. Program sites where the students had previously observed therapy for their Level 1 experience and that were within a 1-hr commute from the school were selected for a survey to assess their receptivity to the ILS model. We have found that students are often unwilling to travel more than 1 hr each way to run weekly groups. The sites were categorized according to suitability for different theory courses and were screened by the academic fieldwork coordinator for staffing stability. The sites were further limited to the number actually needed for student placement in the near future, so as not to alienate the staff at these sites by offering them student help that could not possibly be provided.

We surveyed 67 programs by telephone—16 for pediatrics, 25 for physical dysfunction, and 26 for psychosocial dysfunction—to find out which programs would be interested in providing placements for students using the ILS Level 1 fieldwork model. Of those surveyed, 87% of the pediatric programs, 56% of the physical dysfunction programs, and 69% of the psychosocial dysfunction programs were interested. Those programs not interested in providing placements identified short client lengths of stay as the primary deterrent to using an ILS Level 1 fieldwork model in their settings. Among the interested programs, the most frequently requested ILS topics were fine motor, gross motor, and play skills for children and cooking and shopping, home safety tips, personal appearance and hygiene, and stress management for adults.

Group Protocols

Group protocols for all but one of the requested topics were written by us and four clinicians hired as consultants for the project, with reference to other ILS literature (Burnett, 1982; Caruthers, 1987; Clovis Adult School, 1981; Cole, Sperry, Board, & Frieden, 1979; Starkey & Penn, 1987a, 1987b, 1987c). We eliminated one topic—gross motor skills—because we believed that pediatric gross motor activities would be too close to sensorimotor techniques and therefore inappropriate for Level 1 students to implement.

For each group session, the protocols contained content-specific goals and objectives, activity suggestions, and procedural suggestions for group leaders. The protocols were later revised on the basis of feedback from students who had used them to run groups.

Supervision and Liability

In the advanced group course that had been using the ILS Level 1 fieldwork model, observation had not been part of the experience, and the classroom time was essentially a seminar relating group theory to the students' weekly Level 1 fieldwork experiences. For courses addressing major theoretical approaches to treatment, however, it was necessary to add an observation element to the original ILS Level 1 fieldwork model and to modify the supervision format. The faculty in the theory courses chose to require the Level I students to spend 1 to 2 hr per week in clinical observation and 1 hr per week running groups. The faculty wanted the students to see occupational therapy evaluation and treatment during that observation time. Our clinical sites have been receptive to a weekly 2- to 3-hr student schedule for 10 consecutive weeks.

Regarding supervision, the clinical educators were asked to orient their students to the facilities and then to spend approximately 15 min per week with the students to prepare them for changes in client status prior to the group and to debrief the students after their groups. The amount of supervision that each clinician chose to provide varied among settings and ranged from no supervision during student-led groups to the therapist's co-leading of student groups. The clinical educators were also asked to complete the short form of the Wisconsin Council on Occupational Therapy Education Evaluation of Student Performance for Level I Fieldwork (Wisconsin Council, 1989) for each student and to share the results with that student.

The supervision within the academic setting was tailored for each course. The faculty chose either to discuss the students' fieldwork experiences in class or to have their teaching assistants run seminars for this purpose. One of the four faculty members now using the model includes clinical educator evaluations of student performance in his course grading, and all of the faculty members give students assignments related to the fieldwork experience.

Use of the ILS Level 1 Fieldwork Model

The ILS Level 1 fieldwork model changed all of the Level I experiences at Tufts-BSOT from straight observation to observation and service provision. This change did not necessitate a change in liability coverage, because the university's general liability policy covers the practical, curriculum-related experiences for all students. Liability coverage may differ among schools.

Model Implementation and Evaluation

In the 1988–89 school year, we implemented this model in the major theory courses and expanded its use in the advanced group course. The following sec-
tions summarize the number of students placed, the number and types of placements used for each class, and the results of clinician, student, and faculty surveys about the model. The written surveys we developed for clinicians and students contained a combination of yes/no and open-ended response questions; the faculty surveys contained open-ended questions only. The responses to the latter were examined for recurring themes, and the frequency of theme occurrences was then calculated. Frequency of responses was also calculated for the yes/no questions. The subjects were asked to complete the surveys at the end of the semester. Because different clinician and faculty response patterns were associated with different courses, we have presented the results for each course separately.

**Advanced Group**

In the fall 1988 semester, 14 students enrolled in the advanced group course were placed in seven settings. The types of settings were geriatric day programs, inpatient mental health units, nursing homes, and rehabilitation hospitals. The students generally did not receive supervision while conducting their groups in these settings. The students led cooking, personal appearance, personal hygiene, and stress management groups. All of the clinicians, students, and faculty members in this group returned their surveys.

The clinicians' responses to the yes/no questions on the survey are shown in Table 1. All 7 of the clinicians in this group expressed satisfaction with the ILS Level I fieldwork model and a willingness to take students following this model again. Fifty-seven percent of the clinicians reported spending 1 to 3 hr supervising the students over the 10 weeks, and 43% reported spending 3 to 6 hr. The students' concerns during these supervisory sessions were (a) the clients' safety, (b) the clients' overall goals, (c) the procedures for co-leading groups, (d) dealing with the clients' behavior and setting limits, and (e) the clients' histories, including their medical conditions and after-care plans.

Although only 17% of the clinicians thought the students were anxious about this experience, 66.6% of the students rated their anxiety as high initially; the same percentage reported a decrease in anxiety over the semester. Most of the students (83.3%) found the ILS group protocols helpful, primarily as a source of ideas for activities. The areas of learning identified by the students were similar to those identified by students in other courses (see Table 2).

The faculty for this course believed that the ILS model provided a useful structure for the students and that the group protocols facilitated the students' activity analysis and problem-solving skills (see Table 3).

**Pediatrics**

In the fall 1988 semester, 12 students enrolled in the pediatrics course were placed in six settings. The types of settings were day-care centers, inpatient psychiatric units for children and adolescents, outpatient departments, and special-needs day schools. The students were generally supervised while conducting groups in these settings. The students led or participated in therapist-led sensorimotor, socialization, and visual-perceptual-motor groups. Sixty-seven percent of the clinicians, 92% of the students, and 100% of the faculty returned their surveys.

The 4 pediatric clinicians who responded to the survey were not completely satisfied with this fieldwork model (see Table 1). One clinician reported spending 1 to 3 hr supervising students over the 10 weeks, and 3 clinicians reported spending more than 6 hr. The students' concerns during clinical supervision involved (a) the clients' safety, (b) the adaptation of tasks, (c) anxieties regarding fieldwork, (d) the clients' medical histories, and (e) dealing with the clients' behavior.

### Table 1

<table>
<thead>
<tr>
<th>Question Topic</th>
<th>Advanced Group (n = 7)</th>
<th>Pediatrics (n = 4)</th>
<th>Physical Dysfunction (n = 11)</th>
<th>Psychosocial Dysfunction (n = 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student provided service to clients</td>
<td>100%</td>
<td>50%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Staffing available to provide group without students</td>
<td>43%</td>
<td>75%</td>
<td>64%</td>
<td>43%</td>
</tr>
<tr>
<td>More willing to take Level I students who provide service</td>
<td>100%</td>
<td>50%</td>
<td>82%</td>
<td>100%</td>
</tr>
<tr>
<td>Student groups valuable in future</td>
<td>100%</td>
<td>50%</td>
<td>91%</td>
<td>100%</td>
</tr>
<tr>
<td>Satisfactory structure provided by school</td>
<td>100%</td>
<td>75%</td>
<td>45%</td>
<td>86%</td>
</tr>
<tr>
<td>Students were anxious</td>
<td>17%</td>
<td>25%</td>
<td>36%</td>
<td>71%</td>
</tr>
</tbody>
</table>

*Note.* ILS = independent living skills.

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### Table 2
**Students’ Perceived Learning**

<table>
<thead>
<tr>
<th>Learning Area</th>
<th>Advanced Group (n = 14)</th>
<th>Pediatrics (n = 11)</th>
<th>Physical Dysfunction (n = 14)</th>
<th>Psychosocial Dysfunction (n = 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group leadership skills</td>
<td>100%</td>
<td>36%</td>
<td>50%</td>
<td>17%</td>
</tr>
<tr>
<td>Developing creative adaptations, problem solving</td>
<td>58%</td>
<td>36%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Dealing with realities of clinic</td>
<td>50%</td>
<td>18%</td>
<td>7%</td>
<td>67%</td>
</tr>
<tr>
<td>Rapport building and interaction with clients</td>
<td>33%</td>
<td>46%</td>
<td>57%</td>
<td>50%</td>
</tr>
<tr>
<td>Interacting with supervisor and other professionals</td>
<td>17%</td>
<td>27%</td>
<td>14%</td>
<td>17%</td>
</tr>
<tr>
<td>Confidence</td>
<td>8%</td>
<td>9%</td>
<td>29%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Sixty-seven percent of the students reported feeling anxious initially, and only 46% reported a decrease in anxiety over the semester. Because most clinicians chose to have the students follow specific occupational therapy treatment plans rather than generate their own ideas for treatment, only 9% of the students found the protocols helpful.

The faculty for this course were dissatisfied with the ILS model. They believed the structure of the model could not be easily adapted to pediatric caseloads and that the model restricted the range of programs that the students could observe, because early intervention programs for infants would not be appropriate settings for ILS groups (see Table 3).

### Table 3
**Faculty Survey Results**

<table>
<thead>
<tr>
<th>Course</th>
<th>Amount of Faculty Supervision</th>
<th>Students’ Concerns</th>
<th>Faculty’s Reactions to ILS Model</th>
<th>Student Learning According to Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced group</td>
<td>45 min per week during class</td>
<td>Treatment goals</td>
<td>Satisfied</td>
<td>Application of didactic material to clinical situation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Effect of group on clients</td>
<td></td>
<td>Activity analysis and problem solving through use of protocols</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continuity of client contact</td>
<td></td>
<td>Value of client feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communication with supervisor</td>
<td></td>
<td>Decreased opportunity to observe variety of pediatric settings</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Sharing experiences during class time</td>
<td>Clarification of student’s role in clinical sites</td>
<td>Dissatisfied</td>
<td>Activity adaptation</td>
</tr>
<tr>
<td>Physical dysfunction</td>
<td>16 min per week during scheduled class</td>
<td>Clarification of student’s role in clinical sites</td>
<td>Satisfied</td>
<td>Resource use; used protocols for activity suggestions</td>
</tr>
<tr>
<td>Psychosocial dysfunction</td>
<td>1 hr per week during scheduled class</td>
<td>Clients’ diagnoses</td>
<td>Satisfied</td>
<td>Group leadership skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dealing with clients’ behaviors</td>
<td></td>
<td>Realistic view of clinical practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group leadership</td>
<td></td>
<td>Application of theory to practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OT treatment</td>
<td></td>
<td>Sense of strengths and weaknesses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Roles of other disciplines</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* ILS = independent living skills. OT = occupational therapy.
provided by the school (see Table 1). Twenty-seven percent of the clinicians reported spending 1.5 hr supervising the students over the 10 weeks, 55% reported spending 3 to 6 hr, and 18% reported spending more than 6 hr. The concerns raised by the students in these supervisory sessions involved (a) documentation, (b) the clients' safety, (c) resources for groups, (d) clinical expectations, (e) use of medical terminology, (f) the clients' medical histories, (g) the procedures for co-leading groups, (h) the selection of appropriate activities, and (i) establishing and prioritizing treatment goals.

Fifty percent of the students rated their anxiety as high initially. Only 36% of the students found the group protocols helpful, perhaps because many clinics chose to have the students run groups other than those for which protocols were provided.

The faculty for this course believed that the ILS Level I fieldwork model helped the students learn how to adapt activities and that the group protocols were useful for activity suggestions (see Table 3).

Psychosocial Dysfunction

In the spring 1989 semester, 22 students enrolled in the psychosocial dysfunction course were placed in 11 settings. The types of settings were inpatient mental health units and community day treatment programs. Most of the students were not supervised while conducting groups in these settings. The students led groups on cooking, life skills, money management, relationships, stress management, and women's issues. Sixty-four percent of the clinicians, 27% of the students, and the 1 faculty member teaching this course returned their surveys. The low student response rate in this group may be due to the fact that several students were taking both the physical and psychosocial courses this semester and may have already completed surveys for their physical dysfunction course. Because the number of students reporting on their psychosocial experience was small, the perceived learning results shown in Table 2 may not represent the experience of the total group of students in this course.

The clinicians in this group generally expressed satisfaction with the ILS model (see Table 1). Twenty-nine percent of the clinicians reported spending 1 to 3 hr supervising the students over the 10 weeks, and 71% reported spending 3 to 6 hr. The concerns raised by the students in these supervisory sessions involved (a) time management, (b) the clients' medical histories, (c) clinical expectations, (d) types of client funding, (e) the adaptation of group activities, (f) the procedures for co-leading groups, (g) the students' effects on the clients, (h) the role of occupational therapy and other disciplines, and (i) dealing with clients' behavior and strategies for setting limits. No data were available for this group regarding their perceived levels of anxiety or how useful they found the group protocols.

The faculty for this course believed that the ILS Level I fieldwork model provided useful structure for the students by facilitating the development of the students' observation skills and an understanding of the relationship between theory and practice (see Table 3).

Discussion

The results of the clinician, student, and faculty surveys suggest that the ILS Level I fieldwork model is more appropriate for clinics serving young adult and adult populations than for those serving children. Despite an enthusiastic response from pediatric clinicians during the preliminary telephone survey, many of these clinicians had difficulty implementing the ILS model because their caseloads during the fieldwork experience required one-on-one rather than group treatment. In the young adult and adult settings, the model was slightly more successful in those settings that used group treatment predominantly. The model was most successful in the advanced group course, where supervision in the classroom was the most intensive and where the students did not spend time observing in addition to conducting groups. The major issues raised by these results relate to the mechanics of the model, the provision of client services, and student learning.

Mechanics of the Model

The clinicians' responses concerning their satisfaction with the structure provided by the school and the students' questions concerning their roles in settings in which they were both observing and leading groups indicate that the school's explanations of and communication about the model need to be very clear. The following steps have been taken toward such clarification:

1. A formal memorandum of agreement delineating school and clinic responsibilities for ILS Level I fieldwork experiences has been sent to all clinical sites involved.
2. The Level I Fieldwork Student Manual (Hume & Sadoski, 1990), which explains the placement procedures, the roles of faculty and clinicians in this model, and the students' responsibilities throughout the 10-week experience, has been compiled to orient the students to the model.
More frequent telephone contact with clinicians throughout the 10 weeks and increased processing time for the students' school experiences would also be helpful. An informational session for local clinicians, faculty, and students about this fieldwork model has been developed to work out implementation difficulties. A personal data sheet for students has also been developed to inform supervisors of the kinds of related experience their students bring to Level I fieldwork. The group protocols might be helpful to more students if the school restricted the number of groups offered to those for which protocols were available.

**Provision of Client Services**

In all of the settings that provided services to young adults and adults, the clinicians perceived the students as having provided a service to the clients by co-leading groups. Without students' help, 36% to 57% of these settings would not have had the staff to offer these groups. Most of these clinics would be more willing to take Level I students if the students offered this type of service. The service component of the ILS model, then, appears to have been successful for this population, particularly in psychosocial settings. Most of the psychosocial dysfunction settings would not have had the staff to provide the 10-week groups without the students' help, thus suggesting that these settings may have been experiencing some staffing shortages. Service provision may offer temporary help with staffing shortages and address the cost-effectiveness concerns raised by clinicians about Level I fieldwork (Leonardelli & Caruso, 1986).

Most of the clinicians in the settings that provided service to young adults and adults spent less than 6 hr supervising students over the 10-week experience. The students' service provision time, then, exceeded their supervisory time in most settings. This might also contribute to the cost-effectiveness of this Level I fieldwork model.

**Student Learning**

The students' assessment of their own learning and faculty reports about student learning relative to this Level I model suggest that the students sharpened their clinical skills and began to critically analyze their own practice. Because the students had the opportunity to interact with clients over several weeks, they were able to observe patterns in the clients' responses and overcome obstacles to their initial plans.

Most of the students in the advanced group, physical dysfunction, and psychosocial dysfunction classes identified the development of creative adaptations—problem solving as an area of perceived learning. These students were able to move beyond standard textbook procedures and be flexible in adapting activities to the clients' needs. Students in all classes reported rapport building—interaction with clients as a learning area. Perhaps this is because the students were able to interact with the clients over a period of 10 weeks, thereby allowing both the students and the clients time to get used to each other.

The students also wrote that "Patients are people" and "Patients teach us." Such comments suggest that the students began to see beyond the disabilities to the people living with these disabilities, to understand who these people were and what their disabilities meant to them (Fleming, 1989; Mattingly, 1989). This understanding is an important precursor to the ethical reasoning that allows therapists to understand clients' priorities when they are collaborating with clients to formulate treatment plans (Rogers, 1983).

The mixed reports from the students concerning confidence and dealing with the realities of clinical life suggest some problems in the application of this model across different courses and types of treatment settings. None of the students had experience in leading groups, so it is unlikely that they began this fieldwork experience with total confidence in their skills. Only 8% of the students in the advanced group reported learning confidence, perhaps because they received the least supervision while actually conducting their groups. Only 9% of the pediatric students reported learning confidence; in this case, the fact that the model did not work well with a pediatric population may have led these students to think they were failing regarding school expectations. Only 18% of the pediatric students and 7% of the physical dysfunction students reported learning about the realities of clinical life. Conversely, in the advanced group and psychosocial dysfunction settings, in which group practice was the predominant form of occupational therapy treatment, 50% and 67% of the students, respectively, reported learning about the realities of clinical practice. Perhaps the pediatric and physical dysfunction students thought that they were missing exposure to the individual treatment sessions that were so common in those settings.

A replication of this model in other curricula and longitudinal studies with students who are using this model would be interesting. The expansion of the application of the model throughout a curriculum means that students will need to meet a Level I fieldwork clinical performance requirement that is consistent across courses, that is, they will have to lead an ILS group. Their clinical performance as group leaders could therefore improve, both through practice and by having more new information to inform their practice with every new course. Use of this
model across courses could also help students to see and experience the similarities and differences between practice settings and clinical populations, thus encouraging mental flexibility.

Conclusion

Although there were some communication and organizational problems in the expansion of an ILS Level I fieldwork model across courses in the Tufts-BSOT curriculum, the model appears to have been generally successful regarding the provision of services to clients and student learning in settings that serve young adults and adults and that routinely use group treatment. Further study of this model longitudinally and in comparison with other Level I fieldwork models would be helpful in the determination of what aspects of Level I fieldwork experiences are most useful to clinical sites and what aspects are most effective in the facilitation of student learning.

Acknowledgments

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References


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