

Victorian Department of Health and Human Services

Evaluation of Traineeships for Aboriginal workforce development in Victoria

Final Report

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Abbreviations and glossary of terms

Term	Explanation
Aboriginal	Throughout this document, the term 'Aboriginal' is used to refer to both Aboriginal and Torres Strait Islander people. The term 'Indigenous' is retained when it is part of the title of a report, program or quotation.
ACCHO	Aboriginal Community Controlled Health Organisation
AHA	Australian Healthcare Associates
AHWD	Aboriginal Health Workforce Development
ALO	Aboriginal Liaison Officer
AHW	Aboriginal Health Worker
DHHS	Department of Health and Human Services (also 'the Department')
Grants/traineeships	Includes all support provided through the Closing the Gap and Koolin Balit Training Grants Program, as well as cadetships, graduate training grants provided for nursing, midwifery, allied health, and the Indigenous Training and Recruitment Initiative (INTRAIN) scholarships.
HR	Human Resources
IEP	Indigenous Employment Program
INTRAIN	Department of Health and Human Services Aboriginal scholarships
NAIDOC	National Aborigines and Islanders Day Observance Committee
Recipient	Refers generally to recipients of grants, traineeships, cadetships and graduate programs under the Closing the Health Gap and Koolin Balit DHHS Aboriginal Health Workforce Development (AHWD) Program. References to recipients of a particular program or type of funding are specified, e.g. 'traineeship recipient' or 'trainee'
RTO	Registered Training Organisation
The Program	The Closing the Gap and Koolin Balit Training Grants Program
VPSC	Victorian Public Sector Commission

1. Executive summary

1. Executive summary

Australian Healthcare Associates (AHA) was engaged by the Victorian Department of Health and Human Services (DHHS) to conduct an evaluation of Aboriginal traineeships, cadetships and graduate programs provided through the Closing the Gap and Koolin Balit Training Grants Program (the Program).

This report presents the key findings against each of the four evaluation questions, focussed on traineeship recipients (trainees), and provides examples of the good practices identified. *Appendix A* summarises the enablers and barriers identified and *Appendices B to H* provide specific findings about cadetships and graduates, and further details of the evaluation findings, methodology, literature review and the policy background to the Program.

1.1 Evaluation question 1

Q1. To what extent have Aboriginal workforce grant and traineeship recipients established careers in the Victorian healthcare sector?

Refer to
Chapter 2

The above question was addressed through identifying and analysing the:

- Number of trainees and their training status (completed, ongoing, withdrawn, did not commence)
- Employment status (employed/not) of a sample of trainees. Employment status was used as a proxy for whether trainees have established careers.

A total of 313 traineeships were made available across Victoria, over the five years to June 2015. Seventeen Aboriginal Community Controlled Health Organisations (ACCHOs) hosted 128 traineeships (40.9% of 313) and 46 mainstream organisations hosted 185 traineeships (59.1%). The status of these 313 traineeships at April 2016 was:

- 236 (75.4%) either completed (146) or are ongoing (90)
- 77 (24.6%) either withdrew (62) or did not commence (15).

The profile of trainee status was similar for ACCHO and mainstream organisations, i.e. 77.3% of ACCHO hosted traineeships and 74.1% of mainstream hosted traineeships were either completed or are ongoing.

Employment status was investigated for two (of seven) regions - Hume and Gippsland. Of 79 traineeships hosted in these two regions, 60 (75.9%) either completed training or are ongoing. Of these 60 trainees, 53 (88.3%) were identified as being currently employed, i.e. had established a career. The employment rate was higher for ACCHO hosted trainees (94.4%, 17 of 18) than for mainstream hosted trainees (85.7%, 36 of 42).

Of these 53 trainees (who had established a career), 43 (81.1%) work in the health sector in Victoria. Therefore, of 79 total trainees hosted in Hume and Gippsland regions, 54.4% (43) are considered to have established a career in the Victorian health sector.

1.2 Evaluation questions 2 and 3

Q2. Where grant and traineeship recipients have successfully established careers in the Victorian health system, what have been the critical enablers alongside the grant/traineeship? Where they have not established careers in health, what have been the most significant barriers? (A particular focus has been given to the 'demand-side' of workforce development, i.e. the role of employing organisations.)

Q3. What have been the critical enablers for Aboriginal people who have successfully established careers in mainstream organisations, such as hospitals, within the Victorian healthcare sector?

Refer to
Chapters 3
and 4

1. Executive summary

The above evaluation questions are addressed through identifying key barriers and enablers to career establishment. Differences between mainstream and ACCHO organisations are highlighted where appropriate. *Chapter 3* focuses on the ‘demand-side’ of workforce development, i.e. the role of employing organisations, and *Chapter 4* on broader external factors. The following *Table 1-1* summarises the key enablers and barriers identified.

Table 1-1: Summary of key enablers and barriers

Enablers and barriers	Key elements
Organisation level factors (Chapter 3)	
O1. Organisational readiness	<ul style="list-style-type: none"> • Board, executive and senior management support is evident • Policies that support the employment of and ongoing career development for Aboriginal people • A culturally safe workplace is embedded in organisational leadership, governance and culture • Strong connections exist between host organisations and the local Aboriginal community
O2. Trainee recruitment	<ul style="list-style-type: none"> • Importance is placed on attracting suitable, job-ready trainees • Culturally appropriate selection processes are in place for trainee recruitment
O3. Trainee support during traineeship	<ul style="list-style-type: none"> • Person to person support • Study support • Engaging high-quality, supportive Registered Training Organisations (RTOs)
O4. Post-traineeship career development	<ul style="list-style-type: none"> • Employment opportunities available in the host organisation for externally recruited Program trainees • Opportunities exist for staff to up-skill through the Program
External factors, i.e. those over which trainee organisations have limited influence (Chapter 4)	
E1. Trainee characteristics	<ul style="list-style-type: none"> • Work-readiness • Literacy and numeracy skills • Personal circumstances
E2. Program design and administration	<ul style="list-style-type: none"> • Uncertainty about the timing of grants availability • Lack of clarity about eligibility for grants, i.e. what could be used for • Career development limitations of Program
E3. Policy considerations	<ul style="list-style-type: none"> • Lack of surety about funding • Salary disparities between ACCHO and mainstream organisations

Examples of good practice are identified in each chapter. A full list of enablers and barriers is provided at *Appendix A*.

The most critical enabling factor cited was organisational readiness. High levels of organisational readiness were critical to the recruitment and retention of Aboriginal trainees, both in the Program and also in the health workforce. Trainees and organisational representatives reported that overall, ACCHOs were more organisationally ready than their mainstream counterparts, and in particular ACCHOs provided more Aboriginal-friendly, accommodating and understanding workplaces for trainees.

1. Executive summary

Examples of best practice were also demonstrated in mainstream organisations, particularly in relation to trainee recruitment and support. In some cases, organisations successfully engaged external agencies to assist with recruitment and support. Mentorship was identified as an important trainee support mechanism. Interestingly, having access to non-Aboriginal mentors was not viewed as a major issue, as experience and cultural readiness/acceptability were deemed to be the most critical attributes of a mentor.

1.3 Evaluation question 4

Q4 Are there strategies that have been effective at increasing Aboriginal people's employment in healthcare in other jurisdictions that are not currently available to Victorians?

**Refer to
Chapter 5**

To address the above evaluation question, a literature scan was conducted (*Appendix G*) to identify the range of strategies and programs available, and these were compared with the current Victorian AHWD Program.

This comparison found that versions all of the initiatives identified in the literature scan were observed and reported to be in operation in Victoria. However, strategies differed between host organisations. Successful initiatives in place at some were not utilised by others.

The host organisations consulted indicated that they had limited awareness of strategies and best practice in place at other organisations. There are a variety of networks and opportunities to share information facilitated by the Department that include the Aboriginal Employment Advisory Group, Project Officers Working Group and Aboriginal Graduate and Cadetship Network, Increased promotion of these networking opportunities and other mechanisms across the sector is required.

2 Extent of career establishment

2. Extent of career establishment

Q1: To what extent have Aboriginal workforce grant and traineeship recipients established careers in the Victorian healthcare sector?

The above question was addressed through identifying and analysing the:

- Population of trainees and their training status (completed, ongoing, withdrawn, did not commence)
- Employment status (employed/not) of a sample of trainees. Employment status was used as a proxy for whether trainees have established careers.

2.1 Population of trainees and their training status

Over the five years from July 2010 to June 2015, 313¹ traineeships were hosted by 63 organisations across Victoria. The status of these traineeships at April 2016 is summarised in the following *Table 2-1*.

Table 2-1: Status of traineeships, 2010-11 to 2014-15, at April 2016²

All	2010-11	2011-12	2012-13	2013-14	2014-15	Total	%
Completed	34	58	27	23	4	146	46.6%
Ongoing	2	-	28	40	20	90	28.8%
Subtotal	36	58	55	63	24	236	75.4%
Not commenced	3	1	2	3	6	15	4.8%
Withdrawn	22	17	7	14	2	62	19.8%
Subtotal	25	18	9	17	8	77	24.6%
Total	61	76	64	80	32³	313	100.0%

As shown in the above *Table 2-1*, of 313 traineeships:

- 46.6% (146) were completed
- 28.8% (90) are ongoing
- 24.6% (77) were either withdrawn (62) or did not commence (15).

Traineeships were hosted by 17 ACCHO organisations (128 trainees, 40.9%) and 46 mainstream organisations (185 trainees, 59.1%). The following *Table 2-2* summarises the status of these traineeships.

¹ Analysis is provided of 313 traineeships; for simplicity the term 'trainees' is also used. In fact, there were 297 (not 313) trainees, as 14 people had access to two traineeships and one person to three traineeships.

² The analysis presented is based on information provided by the Department. Some omissions and inconsistencies are apparent in this information and therefore, while the analysis provides a useful overview, its reliability for more detailed consideration is uncertain.

³ There were fewer traineeships in 2014-15 (32) than for other years. The Department advised that this was because the average funding value for these 32 traineeships was higher than for other years. Total funding for 2014-15 was comparable with other years, but comprised relatively fewer traineeships at relatively higher funding per traineeship.

2. Extent of career establishment

Table 2-2: Status of traineeships, ACCHO and mainstream, 2010-11 to 2014-15, at April 2016⁴

ACCHO	2010-11	2011-12	2012-13	2013-14	2014-15	Total	%
Completed	15	31	7	10	-	63	49.2%
Ongoing	-	-	16	18	2	36	28.1%
Subtotal	15	31	23	28	2	99	77.3%
Not commenced	3	-	1	-	-	4	3.1%
Withdrawn	12	7	3	3	-	25	19.5%
Subtotal	15	7	4	3	-	29	22.7%
Total	30	38	27	31	2	128	100.0%

Mainstream	2010-11	2011-12	2012-13	2013-14	2014-15	Total	%
Completed	19	27	20	13	4	83	44.9%
Ongoing	2	-	12	22	18	54	29.2%
Subtotal	21	27	32	35	22	137	74.1%
Not commenced	-	1	1	3	6	11	5.9%
Withdrawn	10	10	4	11	2	37	20.0%
Subtotal	10	11	5	14	8	48	25.9%
Total	31	38	37	49	30	185	100.0%

As shown in the above *Table 2-2*, traineeship status was similar for both ACCHO and mainstream host organisations:

- Completed or ongoing comprised 77.3% of ACCHO hosted traineeships and 74.1% of mainstream
- Not commenced or withdrawn comprised 22.7% of ACCHO hosted traineeships and 25.9% of mainstream.

Analysis was also undertaken to assess whether training status appeared to be influenced by the number of trainees an organisation hosted (few vs many trainees). Over the five-year period analysed:

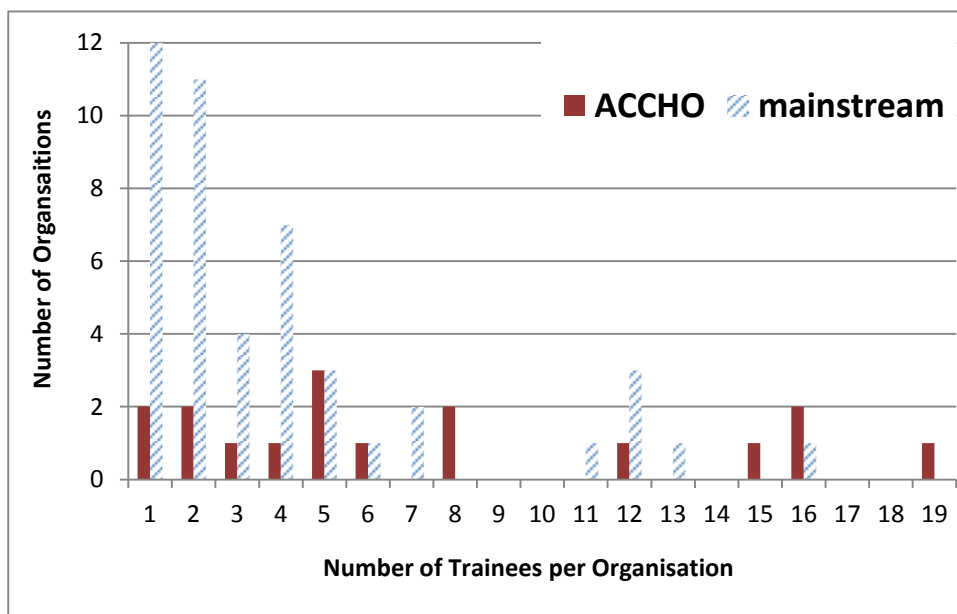
- 17 ACCHO organisations hosted 128 traineeships (average 7.5 traineeships)
- 46 mainstream organisations hosted 185 traineeships (average 4.0 traineeships).

The following *Figure 2-1* illustrates the number of trainees hosted by each of these 63 organisations. For example, it shows that one ACCHO organisation hosted 19 trainees and that 12 mainstream organisations each hosted one trainee.

⁴ The analysis presented is based on information provided by the Department. Some omissions and inconsistencies are apparent in this information and therefore, while the analysis provides a useful overview, its reliability for more detailed consideration is uncertain.

2. Extent of career establishment

Figure 2-1: Number of trainees per organisation, ACCHO and mainstream, 2010-11 to 2014-15



As illustrated, most mainstream organisations hosted four or less trainees. Of 46 organisations, 34 (73.9%) hosted four or less trainees and only five (10.9%) hosted more than ten trainees.

Comparatively fewer ACCHO organisations hosted four or less trainees. Of 19 ACCHOs, only six (31.6%) hosted four or less trainees and five (26.3%) hosted more than ten trainees. These five organisations hosted 78 trainees, 60.9% of all ACCHO hosted trainees.

Analysis indicated that training status (completed, ongoing, withdrawn, did not commence) was similar for organisations, irrespective of whether they hosted few or many trainees. There was no evidence that the number of trainees hosted by an organisation influenced training status outcomes.

Findings

- Of 313 traineeships:
 - 236 (75.4%) either completed (146) or are ongoing (90)
 - 77 (24.6%) either withdrew (62) or did not commence (15)
- This status profile was similar for ACCHO and mainstream organisations; and was similar irrespective of whether the organisation hosted few or many trainees.

2. Extent of career establishment

2.2 Career establishment - Hume and Gippsland regions

Defining what constitutes an 'established career' in the context of Aboriginal workforce, is a complex matter. Concepts of career establishment and success are explored in the separate Final Evaluation Report.

For the purposes of the following analysis, trainees' employment status (employed/not) is used as a proxy for whether they have established a career or not. Current employment status was not routinely collected by the Department during Closing the Gap, however under Koolin Balit training grants this information is now routinely collected. The Victorian Public Sector Commission (VPSC) collects annual data regarding health service employment. The Department and VPSC are working in partnership to improve health service reporting on Aboriginal employment. This study therefore obtained this information for a sample of trainees from Hume and Gippsland, using the following methods.

The Hume and Gippsland regions were nominated by the Department for site visit and more detailed analysis by AHA. The study scope and budget did not allow this to occur across all regions and therefore it was not possible to establish the employment outcomes for all trainees. These two regions were nominated as they are considered to be among the better performing regions, and therefore likely to provide examples of successful methods. Therefore, while the following analysis provides useful insight, it cannot be assumed that these results are generalisable to other regions.

Across Hume and Gippsland, 14 organisations received funding to host 79 traineeships (25.2% of 313 state-wide), over the five years to June 2015. Four ACCHO organisations hosted 19 traineeships and 10 mainstream organisations hosted 60 traineeships.

AHA visited these two regions and conducted in-depth interviews with trainees and host organisations. The current employment status of trainees was identified through:

- Direct contact with trainees through survey completion and/or interview. Of 79 trainees, 16 (20.3%) provided information about their employment status. Information was provided directly by 15.8% of trainees hosted by ACCHOs and 21.7% of those hosted by mainstream organisations.
- Direct contact with 11 of 14 (85.7%) trainee organisations in Hume and Gippsland, through interview and subsequent follow up. Three ACCHO organisations (18 trainees) and eight mainstream organisations (57 trainees) provided information about the employment status of the trainees they hosted.
- Information provided by the Department.

2.2.1 Employment status

As shown in the following *Table 2-3*:

- 79.7% of all trainees are in employment (63 of 79)
- 88.3% of completed/ongoing trainees are in employment (53 of 60)
- 52.6% of not commenced/withdrawn trainees are in employment (10 of 19).

2. Extent of career establishment

Table 2-3: Employment outcomes, Hume and Gippsland trainees, 2010-11 to 2014-15

All	Not employed	Unknown	Employed	Total	Employed %
Completed	1	4	36	41	87.8%
Ongoing	1	1	17	19	89.5%
Subtotal	2	5	53	60	88.3%
Not commenced	-	1	2	3	66.7%
Withdrawn	4	4	8	16	50.0%
Subtotal	4	5	10	19	52.6%
Total	6	10	63	79	79.7%
	7.6%	12.7%	79.7%	100.0%	

The following *Table 2-4* identifies trainee employment outcomes for ACCHO and mainstream organisations.

Table 2-4: Employment outcomes, Hume and Gippsland trainees, ACCHO and mainstream, 2010-11 to 2014-15

ACCHO	Not employed	Unknown	Employed	Total	Employed %
Completed	-	-	11	11	100.0%
Ongoing	1	-	6	7	85.7%
Subtotal	1	-	17	18	94.4%
Not commenced	-	-	-	-	-
Withdrawn	-	-	1	1	100.0%
Subtotal	-	-	1	1	100.0%
Total	1	-	18	19	94.7%
	5.3%	-	94.7%	100.0%	
Mainstream	Not employed	Unknown	Employed	Total	Employed %
Completed	1	4	25	30	83.3%
Ongoing	-	1	11	12	91.7%
Subtotal	1	5	36	42	85.7%
Not commenced	-	1	2	3	66.7%
Withdrawn	4	4	7	15	46.7%
Subtotal	4	5	9	18	50.0%
Total	5	10	45	60	75.0%
	8.3%	16.7%	75.0%	100.0%	

2. Extent of career establishment

As shown in *Table 2-4*:

- Trainees hosted by ACCHO organisations had a higher overall employment rate (94.7%; 18 of 19) compared to mainstream organisations (75.0%; 45 of 60)
- Mainstream organisations hosted 18 of the 19 not commenced/withdrawn trainees. These 18 trainees had a notably lower employment rate (50.0%) than completed/ongoing trainees (85.7%) hosted by mainstream organisations. This factor contributed to the lower overall employment rate for trainees hosted by mainstream organisations (75.0%) compared to ACCHOs (94.7%).

For trainees that are employed (63), information was obtained about the sector they are employed in (health/non) and where they are located (Victoria/not). This identified that:

- 81.0% (51 of 63) work in the health sector, five work in non-health sectors and for seven the sector was unknown
- 81.0% (51 of 63) work in Victoria, and 12 work elsewhere or the location is unknown. These 51 Victorian based people include 46 who work in the health sector.

As shown in *Table 2-3*, 88.3% (53 of 60) of completed/ongoing trainees are in employment, i.e. have established careers. Of these 53 trainees, 43 (81.1%) work in the health sector in Victoria. Therefore, of 79 total trainees hosted in Hume and Gippsland regions, 54.4% (43) are considered to have established a career in the Victorian health sector.

This profile was similar for ACCHO and mainstream organisations, i.e.:

- Trainees who work in health represent 83.3% (15 of 18) of all employed ACCHO hosted trainees; and 80.0% (36 of 45) of employed mainstream organisation hosted trainees.

Trainees who work in Victoria represented 72.2% (13 of 18) of employed ACCHO hosted trainees; and 84.4% (38 of 45) of employed mainstream organisation hosted trainees. As indicated at the start of this Section 2.2, Hume and Gippsland regions were nominated for this study. While the above analysis provides useful insight, it cannot be assumed that these results are generalisable to other regions.

Findings

- **Of 60 trainees who completed training or are ongoing, 53 (88.3%) established a career, i.e. are currently employed**
 - **Of these 53 trainees, 43 (81.1%) work in the health sector in Victoria**
 - **Therefore, of 79 total trainees hosted in Hume and Gippsland regions, 54.4% (43) are considered to have established a career in the Victorian health sector**
 - **The employment rate was higher for ACCHO hosted trainees (94.4%, 17 of 18) than for mainstream hosted trainees (85.7%, 36 of 42).**
-

3 Organisation level enablers and barriers

3. Organisation level enablers and barriers

- Q2.** *Where grant and traineeship recipients have successfully established careers in the Victorian health system, what have been the critical enablers alongside the grant/traineeship? Where they have not established careers in health, what have been the most significant barriers? (A particular focus has been given to the 'demand-side' of workforce development, i.e. the role of employing organisations.)*
- Q3.** *What have been the critical enablers for Aboriginal people who have successfully established careers in mainstream organisations, such as hospitals, within the Victorian healthcare sector?*
-

3.1 Introduction

The above evaluation questions are addressed through identifying key barriers and enablers to career establishment. This *Chapter 3* focuses on the 'demand-side' of workforce development, i.e. the role of employing organisations, and *Chapter 4* on broader external factors. Barriers and enablers are presented as follows:

Organisation-level factors (Chapter 3)

- O1. Organisational readiness
- O2. Trainee recruitment
- O3. Trainee support during traineeship
- O4. Post-traineeship career development.

External factors, i.e. those over which host organisations have limited influence (Chapter 4)

- E1. Trainee characteristics
- E2. Program design and administration
- E3. Policy considerations.

Examples of good practice are provided in each chapter. Differences between ACCHO and mainstream organisations are highlighted where appropriate. In most aspects however, similar enablers and barriers were reported irrespective of whether trainees were hosted by ACCHO or mainstream organisations.

Barriers and enablers to Aboriginal health workforce development identified through the literature scan are presented in *Appendix G*.

3.1.1 Information sources

The information and views presented in *Chapters 3* and *4* were obtained through:

- Direct contact with **trainees** through survey completion and/or interview. Of 297 trainees, 59 (19.9%) completed the survey and 35 (11.8%) were interviewed:

3. Organisation level enablers and barriers

- Of 59 surveys completed, four were from trainees hosted by ACCHOs, 38 by mainstream organisations and 17 did not state their host organisation.
- 35 interviews were conducted with trainees as follows:
 - 14 face-to-face interviews; 5 from ACCHOs and 9 from mainstream organisations
 - 21 telephone interviews; 3 from ACCHOs and 18 from mainstream organisations.
- Direct contact with **host organisations and peak bodies**, through interview and subsequent follow up. Of 63 host organisations, 28 (44.4%) were either consulted face to face (15) or by telephone (13).

These 28 organisations consulted comprised:

 - Seven ACCHOs (of 19), which hosted 72 trainees (56.2% of 128 total)
 - 21 mainstream organisations (of 46), which hosted 134 trainees (72.4% of 185 total).
- **Information provided by the Department**, including 53 case studies.

The seven ACCHOs consulted hosted 56.2% (72 of 128) of ACCHO hosted trainees. Relatively few ACCHO hosted trainees directly participated in the evaluation. Nine (7.0% of 128) were consulted via survey and/or interview, additionally, some of the 17 survey respondents who did not identify their host organisation may have been from ACCHOs. This deficiency was mitigated to some extent by substantial input to the evaluation from ACCHOs about the experience and outcomes for the trainees they hosted.

The mixed method approach used in this evaluation included triangulation of findings from the survey, and in-depth interviews with trainees, host organisations and other stakeholders. These yielded high levels of thematic saturation, thereby providing confidence that the themes presented in this report are likely to reflect the experience of the majority of the trainees.

3.2 O1: Organisational readiness

A high level of organisational readiness was cited as the most critical enabling factor to the recruitment and retention of Aboriginal trainees, both in the Program and in the health workforce. All stakeholders agreed that if an organisation is not adequately 'prepared' to host trainees then attempts to recruit, retain and develop Aboriginal staff will be hindered.

Creation of a work environment that is receptive to Aboriginal employment is at the core of organisational readiness. The key elements of organisational readiness are as follows.

O1: Organisational readiness

01.1 Board, executive and senior management support is evident

01.2 Policies that support the employment of and ongoing career development for Aboriginal people:

- Host organisation acknowledges and supports cultural responsibilities
- Increasing the numbers of Aboriginal employees and ensuring they have ongoing career development and training opportunities is embedded in policy and practice.

01.3 A culturally safe workplace is embedded in organisational leadership, governance and culture:

- Regular cultural awareness training is provided
- All staff are expected to work in a culturally competent manner

3. Organisation level enablers and barriers

- Culturally inappropriate behaviour towards Aboriginal staff by patients and other staff is not tolerated
- All staff are responsible for the care of Aboriginal clients.

O1.4 Strong connections exist between the mainstream organisation and the local Aboriginal community:

- Support from local Aboriginal Elders is sought and nurtured
- Historical factors and Aboriginal cultural perceptions of health services are acknowledged
- Visible indications of an inclusive environment are evident
- The range of health employment options and career pathways available in the mainstream organisation are promoted in the community.

Trainees and organisational representatives reported that overall, ACCHOs were more organisationally ready to accept trainees than their mainstream counterparts. Specifically, ACCHOs provided more Aboriginal-friendly, accommodating and understanding workplaces.

O1.1 Board, executive and senior management support is evident

Organisational representatives identified that high-level support for the Program and Aboriginal employees is crucial, particularly in overcoming any staff resistance to accommodating Aboriginal staff/trainees in the host organisation environment. Examples of this support included Boards deciding to top-up the funding provided to trainees, meet-and-greet sessions between trainees and Board members, and employment of an Aboriginal consultant to work with the Board and staff to enhance organisational readiness.

'If line managers are told we have executive support, the issues go away.' (Mainstream organisational representative)

High-level support was repeatedly cited by organisational representatives as a key enabler to overcoming a lack of organisational buy-in at line manager level.

O1.2 Policies support employment and ongoing career development for Aboriginal people

Organisational representatives reported that organisational policies must support the employment and ongoing career development of Aboriginal employees. This is evidenced by the inclusion and operationalisation of the following key policy elements:

- Acknowledgement and support for Aboriginal staff to fulfil cultural responsibilities.
- Targeted employment and career development of Aboriginal staff
- A culturally safe workplace is prioritised (see O1.3).

O1.3 A culturally safe workplace is embedded in organisational leadership, governance and culture

Culturally safe workplaces were considered crucial to the retention of Aboriginal staff in host organisations. Mainstream organisations sought to achieve cultural safety through cultural awareness training, induction programs and policies and practices.

'Saying you've done cultural awareness training is not enough.' (Mainstream organisational representative)

3. Organisation level enablers and barriers

Most mainstream organisations reported providing **cultural awareness training** to their staff. Many also reported having **Aboriginal-specific elements in their induction programs**. However, once-off training was not seen to be sufficient. Many of the organisational representatives spoken to recognised that this training needed to be repeated every few years because of staff turnover. The cost of training and back filling positions were cited as the key barriers to this occurring. Furthermore, if training was seen as a ‘tick-box’ or compliance activity and/or if this training did not result in behavioural change among staff, cultural issues were considered likely to remain.

One of the clearest indicators that a mainstream organisation prioritised cultural safety in the workplace was through **senior management’s expectation that all staff work in a culturally competent manner**. This expectation was supported through **policies and practices** that did not tolerate culturally inappropriate behaviour or demands.

Racism was identified as an important barrier in the workplace for Aboriginal people. However, it was most often discussed during consultations as being an indicator of the organisation’s cultural commitment. If a host organisation is not committed to cultural safety and awareness, racism may occur which, in turn, can result in a ‘culturally unsafe’ workplace.

‘We see this [cultural awareness and organisational readiness] as forever business and not just a project.’ (Mainstream organisational representative)

Examples of workplace-based racism cited by trainees in their survey responses and during interviews included:

‘I got accused of playing the Koori card’

‘I got it from staff members – why are Aboriginals not whites getting this funding? I felt deflated’

‘Cultural awareness courses need to be compulsory across all the seniors of departments because that’s where it starts’.

Culturally inappropriate behaviour by clients towards Aboriginal staff was also seen as a barrier to staff retention by both trainees and organisational representatives, and one that needed to be addressed at the organisational level to ensure a culturally safe workplace.

Unrealistic expectations and demands on Aboriginal staff and related burnout was reported as an issue in some organisations. In mainstream organisations, these demands may result in staff being reluctant to identify as Aboriginal and can make the workplace culturally unsafe. Organisations need to be aware of, and limit these demands if they are not to become a barrier to identification as an Aboriginal person or retention in the workforce. These demands can emanate from within the organisation or from the community.

‘If you’re Aboriginal, everything black ends up on your plate.’

‘You just need to be careful. [Aboriginal staff] don’t get burnt out...the community expect them to be on duty 24/7 so educating them on how to support themselves and how not to get burnt out is important.’

‘There can also be more expected of you from other hospital staff – if there’s an Indigenous patient, you’re the one being asked about their care and you get more involved. The community will also seek you out if they come to hospital.’ (Trainee in mainstream organisation)

3. Organisation level enablers and barriers

While cultural safety was generally seen as more of an issue in mainstream organisations, the potential for a culturally unsafe work environment was also reported for ACCHO staff recruited from outside the local community.

01.4 Strong connections exist between host organisations and the local Aboriginal community

Organisational representatives reported that the organisation's level of Aboriginal community engagement was extremely important for the success of the Program.

Examples of the ways mainstream organisations undertake engagement and relationship building to facilitate strong connections to the local Aboriginal community included:

- Working closely with ACCHOs
- Facilitating and supporting culturally significant events (e.g. National Sorry Day, National Aborigines and Islanders Day Observance Committee (NAIDOC) week)
- Including Aboriginal Liaison Officers (ALOs) on staff and on committees
- Presentations regarding Program opportunities to local community members
- Attendance at Aboriginal community events and careers days/expos
- Facilitating on-site events between organisational and community leaders (e.g. dinners attended by board members and Aboriginal Elders)
- Hosting local Aboriginal art shows.

'The organisation needs to be at community events – it's an investment in the Aboriginal community.'

If you don't get buy-in from the Elders, it's a waste of time. The key is being respected by the community.'
(Mainstream organisational representative)

Having the **support of local Aboriginal Elders** for the Program was seen as being very important by both ACCHOs and mainstream organisations, for the standing of the Program in the community. To facilitate this, in some cases, mainstream health services ensured local Elders were consulted and kept informed about the Program through meetings, or less formally through health service personnel attending local Aboriginal events.

Relationship building with the local community was seen as a key strategy to acknowledge and address the **historical factors and cultural perceptions of health services** and the possible barriers these perceptions posed to the use of, and engagement with, health services. This was particularly necessary in the case of mainstream services because historically, hospitals were places that people went to die and where babies were 'stolen'. Given that many trainees who participated in the Program viewed working in health as a way of giving back to the community, it is important that negative perceptions be overcome so that future Program recruitment is facilitated.

Visible indicators of an inclusive environment at mainstream health services were well received, not only by trainees but also by members of the wider Aboriginal community. Examples of these indicators included displaying Aboriginal paintings (usually by local artists) and artefacts, and providing meeting spaces or dedicated areas for members of the Aboriginal community in the organisation.

3. Organisation level enablers and barriers

Lack of familiarity with role or career options in health can be a barrier to candidates applying to the Program. **Promotion of health employment options and career pathways** through organisational initiatives such as trial experiences (O2.2), attendance by host organisations at primary/secondary school events, and provision of school-related work experience opportunities did much to address this barrier. However, lack of staff availability and funding were cited as barriers to providing trial experiences and being able to attend career expo type events in some organisations.

Despite ACCHOs generally having stronger relationships with their local Aboriginal community, both ACCHOs and mainstream organisations had to actively work on securing the support of their local Aboriginal Elders and promoting the range of health employment options and career pathways available through the Program.

3.3 O2: Trainee recruitment

Human resource professionals and other host organisation representatives reported that appropriate trainee recruitment practices were highly important to the success of the Program and to the longer-term retention of trainees in the health sector post-traineeship. If trainee recruitment is not culturally appropriate and targeted (i.e. matched to roles), then high dropout rates occur. Key enablers and barriers are as follows.

O2: Recipient recruitment is culturally appropriate and targeted

O2.1 Importance is placed on attracting suitable, job-ready trainees:

- Culturally appropriate forms of advertising are used
- Recruitment for traineeships is for positions that are needed
- Trainees are selected on the basis of their:
 - Match to role rather than being hurriedly identified and appointed when funding is secured
 - Performance during ‘taster’ programs
 - Prior experience in role and/or organisational familiarity, e.g. volunteer role.

O2.2 Culturally appropriate selection processes are in place for trainee recruitment:

- Aboriginal people on selection panel
- Informal interviewing environment
- Engagement of external agency staff who know the local community, to assist the organisation with recruitment.

O2.1 Importance is placed on attracting suitable, job-ready trainees

Advertising through conventional channels such as on the organisation’s website and in mainstream newspapers did not always attract Aboriginal candidates to mainstream Program opportunities. Mainstream organisations attributed this to the Aboriginal community’s preference for other forms of print media or websites, and their cultural preference for relational or word-of-mouth communication.

3. Organisation level enablers and barriers

Host organisations (ACCHOs and mainstream) that adopted a targeted approach to trainee recruitment tended to report better longer-term outcomes. These approaches involved a mix of formal and informal mechanisms, including:

- Use of Aboriginal-specific media such as *The Koori Mail*
- Placement of notices in Aboriginal organisations
- Formal/informal presentations to the local Aboriginal community
- Word-of-mouth communication between organisational staff (e.g. ALOs) and local community members through youth, women's or men's groups
- Engagement with third-party organisations with links to the local community such as Whitelion⁵, Indigenous Prospects, Training & Recruitment⁶, and region-specific services such as the Latrobe City Council Indigenous Employment Program (IEP).⁷

Trainee recruitment and retention was more successful when focused on traineeships in areas of workforce need rather than to traineeship positions that are unlikely to result in a job. This is particularly important in regional areas where jobs may not be available in some disciplines and turnover rates are very low. Training people for non-existent jobs was seen as a negative outcome for the host organisation and the trainee. It also runs the risk of damaging Aboriginal community confidence in the Program and potentially the host organisation.

02.2 Culturally appropriate selection processes are in place for trainee recruitment

The **cultural appropriateness of trainee selection processes**, particularly interview processes, emerged as an important enabling factor in Program recruitment. In mainstream organisations, the importance of having an Aboriginal person on the interview panel was repeatedly stated by organisational representatives.

Some mainstream organisations also sought to reduce the formality of the interview process, constructing the engagement in terms of 'a chat'. In one case, interviews were conducted outdoors under a tree. Some mainstream organisations involved an external third party agency in the trainee recruitment process. This third-party agency had been working with young Aboriginal people on work readiness issues, knew individual applicants and was able to assist the mainstream organisation in matching applicants with available traineeships. Several mainstream organisations and ACCHOs highlighted the need for clear, transparent trainee recruitment protocols and processes. Some ACCHO-based trainees reported their organisation to be lacking appropriate detail in this area.

Key selection considerations that maximised the likelihood of a successful outcome of the traineeship, for both the trainee and host organisation, included:

- **The trainee is matched to the role rather than being hurriedly appointed when funding is secured.** Mismatching candidates and roles was particularly problematic in cases where organisations secured funding without having a prospective and appropriate candidate in mind.

⁵ Whitelion supports disadvantaged young people, helping them 'off the street, out of jail and into a job'.
<http://www.whitelion.asn.au/>

⁶ Indigenous Prospects, Training & Recruitment specialises in helping job seekers develop the necessary skill for a successful employment interview and obtaining a working position in any of the available vacancies, through their specialised training programs. They also help employers find suitable candidates and provide training where necessary in order to guarantee that the prospect is adequately qualified for the job. <http://www.iptr.com.au/about-us/>

⁷ http://www.latrobe.vic.gov.au/Our_Community/Indigenous_Services/Indigenous_Employment

3. Organisation level enablers and barriers

This seemingly ad hoc and arbitrary process was reported to often yield sub-optimal recruitment and selection outcomes from both the organisation's and candidate's perspective. This practice was reported to be more common in mainstream organisations but did also occur occasionally in ACCHOs.

- **Selection based on performance during work experience or 'taster' programs.** Some mainstream organisations provided candidates with a taster/trial/work experience (Bairnsdale Regional Health Service, Latrobe Regional Health Service, Central Gippsland Health Service, Gippsland Lakes Community Health, and West Gippsland Healthcare Group). This consisted of several weeks' (usually 3-6) work experience (sometimes paid). During this time, prospective trainees had the opportunity to rotate through different departments in the organisation and be exposed to different roles. Final selection of candidates was made at the end of the trial period following an informal interview. Feedback from the candidate's supervisor(s) was also taken into consideration. Several mainstream organisations reported that candidates often 'blossomed' during the trial period, with growth in confidence and self-esteem evident. As a result, some candidates who did not perform well in the initial interview with the organisation, subsequently became the candidate of choice as their capabilities and potential became evident during the trial period.
- **Prior experience in role and/or organisational familiarity** (e.g. volunteer role). Known candidates were reported to have had higher Program completion rates and higher levels of work readiness than those who were externally recruited. These known candidates included existing staff or volunteers working at the host organisation, and funding was primarily used for up-skilling purposes and/or to formalise qualifications.

ACCHOs are more likely to use culturally appropriate recruitment processes than mainstream organisations

For optimal outcomes both ACCHOs and mainstream organisations should recruit suitable job ready trainees to positions that are needed.

3.4 O3: Trainee support

Trainee support during the Program was reported as an important enabler to retention in, and completion of, the Program. If trainees do not receive adequate support from host organisations, they are at greater risk of not completing the Program and therefore may miss the opportunity to either enter or advance in the health workforce. Three key types of organisational support were identified during consultations, as summarised below.

3. Organisation level enablers and barriers

O3: Recipient support provided by host organisation

O3.1 Person to person support:

- Mentoring
- Clinical supervision
- Support for challenging personal circumstances
- Work-readiness support
- Peer support opportunities.

O3.2 Study support:

- Access to appropriate study leave entitlements.
- Additional support to address any literacy/numeracy or IT issues
- Appropriate study space (free from work demands).

O3.3 Engaging high-quality, supportive Registered Training Organisations (RTOs).

O3.1 Person to person support

Person-to-person support takes multiple forms, as follows.

Mentoring by a trained, culturally-aware mentor was identified as an important support and the majority of trainees surveyed/interviewed had access to either a formal or informal mentor. These mentors comprised a mix of Aboriginal and non-Aboriginal mentors. Having access to non-Aboriginal mentors was not viewed as a major issue, as experience and cultural readiness/acceptability were deemed to be the most critical attributes of a mentor. In some host organisations, previous trainees, Program co-coordinators, Aboriginal Employment Officers or the ALO performed the role of mentor for new trainees.

'A mentor needs to be an experienced person who is culturally ready and culturally acceptable.' (Trainee)

Most mentors had not received formal mentoring training and host organisations generally lacked the capacity to independently develop a training program. The need for funding for mentoring programs was frequently cited by organisational representatives. In a small number of host organisations, highly positive experiences were reported where externally trained mentors worked not only with trainees, but with their managers.

Clinical supervision was important for assisting trainees to feel comfortable with the tasks expected of them, and in ensuring safe practice and building confidence. Survey respondents and trainee interviewees highlighted the importance of having an understanding supervisor who was aware of, and understood, the trainee's family and community commitments.

Host organisations that were cognisant of the potential need to provide trainees with **support for challenging personal circumstances** were more likely to be able to assist in addressing these issues. When issues were addressed in partnership with the trainee, the best possible outcome for the organisation and the trainee were generally obtained.

Organisational representatives reported that many Program trainees required **work-readiness support**. This support included assistance with completing forms, interview preparation, and education on work

3. Organisation level enablers and barriers

etiquette issues such as the need to supply a medical certificate for sick leave. Aboriginal employment officers played a key role in supporting Aboriginal staff within organisations. In some host organisations, this task was the responsibility of the HR department or supervising staff.

Rectifying work-readiness issues post-employment was reported to be costly and time-consuming for host organisations. The role of, and need for, external organisations to be involved in improving work readiness was highlighted by many host organisations, particularly those providing pre-employment training or post-employment mentoring services. In Gippsland, for example, the Latrobe City Council IEP played a crucial role in this regard, providing individualised support to candidates which, in one case, extended to supporting a trainee to prepare for an interview.

Peer support was seen as an important factor, by both trainees and organisational representatives, in helping trainees avoid feeling isolated and in providing mutual support during training. The extent to which this was used in organisations varied and was often limited in mainstream organisations by small numbers of trainees and low numbers of Aboriginal employees. Some organisations sought to offset this sense of isolation by bringing all Aboriginal employees together fortnightly to see how they were going in their training and personal life.

Organisational representatives' views differed on whether there was a need to have more than one trainee in a host organisation. Some organisations felt it crucial to have more than one trainee for mutual support purposes while others considered other forms of support such as mentoring to be more important than trainee-to-trainee support. Trainee recruitment policies differed depending on the viewpoint taken.

Trainees who had other Aboriginal trainees in the organisation with them reported that *'it was useful having someone else studying with you'*.

'It would be useful to have access to Aboriginal people who went through that particular course, and now work in the area or can provide information about other scenarios/pathways.'
(Trainee)

03.2 Study support

Study support in mainstream organisations included time off to study, providing access to computers, providing an appropriate study space (free from the demands of work) and academic support to assist in completing training/assignments. Those organisations that provided tutors as part of their study support reported high levels of attendance at tutor sessions. In some cases, Program funding was used to cover course fees, books, travel and backfill while trainees were away on placements.

Less study support was reported by trainees hosted by ACCHOs than by mainstream organisations. ACCHOs however, often had a senior person (e.g. a registered nurse or a member of the social work or management team) available to help trainees if needed.

The provision of study time (sometimes within work hours) and study leave was reported by trainees as an important enabler to Program completion.

03.3 Engaging high-quality, supportive RTOs

The careful selection of high-quality, supportive RTOs by host organisations, was highlighted as an important enabling factor by trainees, organisational representatives and peak bodies. However, organisations and trainees reported low levels of support being provided by some RTOs involved in the

3. Organisation level enablers and barriers

Program. Trainees reported needing technical support (to access online materials) as well as study assistance.

Organisations indicated that finding suitable local trainers to deliver courses could often be problematic. As a result, trainees had to complete online components and/or travel as part of their training. Some trainees had never used a computer and organisations had to provide high levels of support in these cases. In situations where trainees had to travel, organisations incurred travel costs as well as accommodation and lost productivity costs for some trainees. For these reasons, some organisations indicated a preference for the provision of on-site training.

Limited access to and frequent turnover of trainers proved disruptive to trainees. Some trainers failed to undertake scheduled site visits while others provided minimal feedback on work presented. This lack of external support posed an additional support burden on host organisations. Poor levels of support by training providers were a key barrier to qualification completion cited by trainees.

Some course requirements were reported to be logistically challenging for host organisations, in particular the requirements for trainees undertaking Certificate III and IV courses to complete up to 200 hours of placement. Health services had a preference to rotate trainees through multiple departments/areas of the host organisation. Facilitating and supporting these placement hours and rotations were difficult for some organisations, albeit they recognise the benefits for trainees.

Provision of a range of supports to trainees was crucial to Program completion in both ACCHOs and mainstream organisations.

3.5 O4: Post-traineeship career development

Retaining trained staff in the host organisation after completion of their training was reported to be the goal of many organisations, and the reason for their 'investment' in the trainee. Consultations with trainees, organisational representatives and peak bodies indicated that the absence of post-Program employment and career development opportunities may mean that:

- The value of the Program can be diluted or seen as tokenistic
- Trainees may be unable to remain employed in health as the Program intends.

If trainees do not obtain employment, the local community may develop a 'lack of faith' in host organisations and the Program. Such negative perceptions could pose further challenges to the recruitment of candidates for future Aboriginal workforce development initiatives.

Organisational representatives indicated that post-traineeship career development opportunities were being facilitated through a number of means, i.e. these were key enablers, as follows.

'Development for the sake of development is useless if there is nowhere to put people.'
(Organisational representative)

3. Organisation level enablers and barriers

O4: Post-traineeship career development

O4.1 Employment opportunities available in the host organisation for externally recruited Program trainees:

- Reserving positions in the area of work in which the traineeship was completed
- 'Casual Pool' staffing, preferably with the allocation of a guaranteed number of work hours per week

O4.2 Opportunities exist for staff to up-skill through the Program

O4.1 Employment opportunities available in the host organisation for externally recruited Program trainees

An important enabler to career development is the presence of suitable vacant positions within host organisations. This is reliant on:

- Positions being planned and funded
- An understanding that there is often limited turnover in entry-level positions so this needs to be taken into consideration when planning to take on additional trainees.

Strategies used by mainstream organisations to provide post-Program employment opportunities included reserving positions and including former trainees in a pool of permanent part-time/casual staff used to fill roster shortfalls. Staffing pools guaranteed trainees a minimum number of hours per week and ensured a continuing relationship with the host organisation. Organisations reported encouraging and supporting qualified trainees (some of whom may be in the 'pool') to apply for vacancies as they became available.

One ACCHO reported that the organisation only participated in hosting Program trainees if they expected to have a job for trainees on completion. This decision was based on their view that training a person and not giving them ongoing work was unacceptable for the organisation, the trainee and the community.

Trainees, organisational representatives and peak bodies acknowledge that in the case of externally recruited trainees, the Program played an important role in providing an initial pathway into the workforce without which, career establishment and development would not have been possible. The Program also facilitated relationship-building between the host organisation and the externally-recruited trainees, which often resulted in ongoing employment.

O4.2 Organisations provide opportunities for staff to up-skill through the Program

Organisational representatives reported that the Program was often used to **up-skill existing staff**. This was identified as being instrumental in the career development of trainees and also contributed to staff retention in organisations. Those trainees who were existing staff members generally remained in the organisation (both ACCHO and mainstream) upon completion of their traineeship.

Consultation with trainees supported this view. As identified in *Section 2.2*, 53 trainees from the Hume and Gippsland regions had successfully established a career, i.e. are currently employed. Fifteen (28.3%) of this cohort were directly consulted with for this study (via interview and/or survey), and over half of those consulted (8 of 15; 53.3%) reported that they had been employed by the same organisation prior to training. These trainees spoke positively of the benefits of up-skilling. The traineeship program appears to be particularly efficient in upskilling and retaining Aboriginal staff in mainstream health services.

4 External enablers and barriers

4. External enablers and barriers

The preceding *Chapter 3* identifies organisation level factors which potentially influence career outcomes for trainees. In addition, there are external factors over which host organisations have limited or no control. These external factors are presented in this chapter under the following headings:

- E1 Trainee characteristics
- E2 Program design and administration
- E3 Policy considerations.

4.1 E1: Trainee characteristics

The following characteristics of trainees can significantly influence training and career outcomes.

E1: Trainee characteristics	
E1.1	Work-readiness <ul style="list-style-type: none">• Retention in the Program and in the health workforce generally is limited for trainees who are unable to meet the demands of working in the health system
E1.2	Literacy and numeracy skills <ul style="list-style-type: none">• Inadequate literacy and numeracy skills limits the opportunity for access to the Program and also for career advancement through further training
E1.3	Personal circumstances <ul style="list-style-type: none">• Adverse personal circumstances may impact the trainee's ability to complete their training or continue in their role and develop their career.

E1.1 Work-readiness

For both ACCHOs and mainstream organisations, trainees' familiarity with the organisation and prior experience in the role, were reported to serve as key facilitators to retention in the Program. Internal candidates were already familiar with the requirements of working within the health sector, and therefore had higher levels of work-readiness than externally recruited trainees.

Lack of work-readiness manifests itself in several ways that impact on host organisations. Absenteeism was reported by organisational representatives as one of the major indications of being work-ready. This presented logistical problems including rostering, backfilling and supervisor commitment issues. Behavioural/workplace etiquette issues were also indicators of a lack of work readiness. Examples cited by organisational representatives included a non-professional manner when relating to clients face-to-face or by telephone, and issues with confidentiality relating to patient information.

E1.2 Literacy and numeracy skills

Host organisation representatives reported that the limited literacy and numeracy skills of potential trainees imposed restrictions at various stages in the career cycle. Those with limited skills in these areas:

- Were generally less work ready
- Struggled to comply with the role-related administrative demands of the workplace (e.g. completing timesheets, writing up notes, filling out forms)
- Had a reduced capacity to undertake further training in career development longer term.

4. External enablers and barriers

Inadequate literacy and numeracy skills not only represent a barrier for individual trainees but were also reported to be a barrier from a host organisation perspective. To work in health organisations, candidates need to have adequate skills to achieve the competency in the administrative and reporting requirements of their role. While host organisations can provide some support with study/training, acquisition of the prerequisite literacy and numeracy skills typically occurs in the pre-employment phase (i.e. in the education system or during pre-employment courses). Deficits in these skills therefore represent a major barrier for trainees hoping to develop a career in health, as host organisations may not have the resources to invest in up-skilling literacy and numeracy skills post-employment.

E1.3 Personal circumstances

Personal circumstances, particularly those related to family and community commitments were identified by trainees and organisational representatives as a potential barrier to a trainee's ability to carry out their work duties. Cultural and family leave was often included in trainee work agreements by utilising accrued leave to cover their absence. Furthermore, the burden of personal circumstances often posed a barrier not only to trainees remaining in the Program, but also to remaining in the organisation on completion of the Program and/or their availability to undertake further training as part of their career development.

While many mainstream organisations worked to accommodate and address these personal circumstances, some were hampered by the trainee not disclosing difficulties they were experiencing.

Providing the level of support needed by trainees to deal with difficult personal circumstances tended to be most problematic in mainstream host organisations with low numbers of Aboriginal staff where trainees had to rely on already overburdened Aboriginal Health Workers (AHWs) and or ALOs.

'When recipients start to feel overwhelmed, they don't speak up. It takes a lot of time to build relationships and it's time consuming to get people back on track' (Mainstream organisational representative).

'Our ALO works with patients and with the recipients but is run off...[their] feet' (Mainstream organisational representative).

4.2 E2: Program design and administration

Aspects of the design and administration of the Program were reported as barriers by organisational representatives which, in turn, influence Program outcomes for trainees.

E2: Program design and administration

E2.1 Uncertainty about the timing of grants availability

E2.2 Misunderstanding regarding eligibility for grants, i.e. what could be used for:

- Perception the Program is primarily focussed on clinical roles. Perceived absence of grants for non-clinical roles seen as a key gap

E2.3 Career development limitations of the Program:

- Program perceived to focus on entry-level positions
- Further training needed for career advancement
- Lack of clarity for some trainees about career progression opportunities.

4. External enablers and barriers

E2.1 *Uncertainty about the timing of grant availability*

Host organisations (ACCHOs and mainstream) reported that uncertainty about the timing of grant availability made it difficult for them to budget or plan. This was a potential barrier to organisational involvement in the Program and in the provision of positions for trainees on completion of their traineeship.

E2.2 *Misunderstanding about eligibility for grants, i.e. what could be used for*

A mismatch was evident between the scope of the traineeship specified by the Department and organisational representatives' understanding of what the Program could be used for. Organisations believed training was not available for roles such as catering, cleaning, linen services, porter services and gardening. This perception was based on:

- The stated aims of the Program, i.e. “to provide opportunities for formal skills development for existing health service staff and/or new traineeships in management, nursing, allied health, dental, physical activity, primary health, alcohol, other drugs and mental health, personal care, health technician and health administration” (Department of Health and Human Services, 2015)
- The eligibility criteria specified for the Program. The range of funding options has increased over time, as summarised in *Appendix B*. There was misunderstanding about the types of health roles eligible for the Program.

E2.3 *Career development limitations of Program*

Eligibility criteria were reported by some organisational representatives as restricting the use of Program funding for the career development of individuals who had previously received funding under the Program.⁸

The absence of ongoing positions available, particularly for externally-recruited trainees, was reported to be a key barrier to career development. This was in part due to an over-supply of entry-level positions in some regions relative to the number of ongoing positions available. Health services determined what role and level of position they recruited to for the traineeship.

Further training is a potential pathway to career development. From an organisational perspective, lack of funding meant that host organisations were often not in a position to support recipients to undertake further training. Also, as indicated previously (*Section E1.2*), the limited literacy and numeracy skills of some trainees and staff may preclude them from undertaking such training.

It was reported that some candidates and trainees lacked an understanding of where a traineeship could lead career-wise, and therefore may not recognise grants/traineeships as a career-development opportunity. Host organisation strategies to expand this understanding included community engagement, provision of trial periods and providing opportunities for candidates and recipients to ‘link with people already in roles and explore how they got there’ (refer to *Chapter 3*).

⁸ Despite these restrictions, 14 recipients accessed traineeships twice and one person three times.

4. External enablers and barriers

4.3 E3: Policy considerations

Policy-related barriers identified during consultations can be categorised into two aspects; those related to program funding and those related to salary disparities between ACCHO and mainstream organisations.

E3: Policy considerations

E3.1 Lack of surety about funding

This may make it difficult for organisations to:

- Plan their involvement in the Program
- Meet in-kind costs associated with supporting recipients through the Program
- Provide post-Program employment opportunities.

E3.2 Salary disparities between ACCHO and mainstream organisations

- Pay disparity and perceived better opportunities in mainstream organisations may lead to poaching of trained recipients from ACCHOs.

E3.1 Lack of surety about funding

Some organisations reported that low levels of Program funding, mean that they have to provide high levels of in-kind support. This support involves a mix of direct and indirect costs incurred through covering for example, supervision, mentoring, provision of academic support, study spaces and study leave, backfilling of supervisor/mentor positions or staff absences during training, and the cost of materials such as books and stationery. Addressing issues related to work readiness (E1.1) also involves in-kind support in many cases, with some host organisations reporting that *‘the organisation spends half the year working on work readiness.’*

These costs may be a barrier to the level of support a host organisation can provide to trainees as well as a barrier to the host organisation’s future involvement in this or similar Programs.

E3.2 Salary disparities between ACCHO and mainstream organisations

Salary disparity was reported to exist between mainstream organisations and ACCHOs, i.e. employees working in mainstream organisations have a higher earning capacity than those working in ACCHOs. This disparity was reportedly a barrier to staff retention in ACCHOs.

It was reported that mainstream health organisations ‘poach’ qualified staff from ACCHOs. While this attests to the employability of qualified Aboriginal staff within the health sector, there is a danger that ACCHOs could become caught in a perpetual cycle of investing in training only for trainees to be poached when qualified. This cycle would be a barrier to ACCHOs’ ability to develop their staff and their organisations.

5 Comparison of Victorian strategies with other jurisdictions

5. Comparison of Victorian strategies with other jurisdictions

Q4: Are there strategies that have been effective at increasing Aboriginal people's employment in healthcare in other jurisdictions that are not currently available to Victorians?

To address the above evaluation question, the current Victorian AHWD Program was compared with other initiatives and programs identified in a literature scan. Details are provided at *Appendix F* and are summarised below.

5.1 Literature scan

The literature scan conducted highlighted the complexity and multiplicity of factors that underpin successful AHWD. The scan:

- Identified a range of specific initiatives to achieve successful AHWD
- Emphasised the importance of deploying multiple strategies simultaneously (i.e. a package approach) to achieve optimum outcomes.

Key examples of successful package approaches identified in the literature scan include:

- Tjirtamai Model in Queensland (West, West, West, & Usher, 2011)
- Indigenous Nursing Support Model: Helping Hands at the University of Southern Queensland (Best & Stuart, 2014)
- Aboriginal Careers in Mental Health (ACIMH) program in NSW (EJD Consulting and Associates, 2014)
- Vision 20:20 program in New Zealand (Curtis & Reid, 2013)
- Thursday Island James Cook University (JCU) Campus (James Cook University, 2016; Usher, Lindsay, & Mackay, 2005)
- Recruitment and Retention of Alaska Natives in Nursing (Project RRANN) in Alaska (DeLapp, Hautman, & Anderson, 2008).

Common to all of these AHWD strategies is the variety of initiatives that were implemented in a coordinated way, to provide a holistic and consistent support package to increase Aboriginal participation in the health workforce.

5.2 Victorian context

Variations in approach were evident within and between health regions and different approaches have been used over time.

Versions of all of the initiatives identified in the literature scan were observed and reported to be in operation in Victoria. Supports and activities undertaken during recruitment, and in furthering career development and staff retention. Examples include providing access to mentors/role models, creating an inclusive workplace, and developing connections with the local Aboriginal community.

5. Comparison of Victorian strategies with other jurisdictions

While all of the initiatives identified in the literature scan were available in in Victoria, different combinations of initiatives had been implemented in organisations. These initiatives formed the basis of the list of organisational enablers and external barriers presented in *Chapters 3 and 4* respectively.

Some successful Victorian initiatives were not identified in the literature scan but were highlighted during the stakeholder consultations. Of particular note was the key role external organisations can play in improving work readiness, through pre-employment training or post-employment mentoring. There is a paucity of Victorian Aboriginal workforce literature.

For example, the Latrobe City Council Indigenous Employment Program provided individualised support to candidates in Gippsland such as supporting a trainee to prepare for an interview. This strategy was seen as highly successful; however comparable external agency participation was not reported in most regions consulted.

The host organisations consulted indicated that increased awareness of strategies and sharing of best practice examples occurring at other organisations would be beneficial. Department facilitated networks and groups that include the Aboriginal Employment Advisory Group, Project Officers Working Group and Aboriginal Graduate and Cadetship Network can assist.

There appears to be an opportunity to further improve information and strategy sharing between organisations, whether through the POWG or other mechanisms.

Findings

Versions of all of the initiatives identified in the literature scan were observed and reported to be in operation in Victoria in some form. However, host organisations combined different strategies and combinations of initiatives. The host organisations consulted indicated a need to increase awareness of strategies being deployed at other host organisations and opportunities to share best practice examples. The Department could have a greater role in facilitating and supporting network opportunities such as the Aboriginal Employment Advisory Group, Project Officers Working Group and Aboriginal Graduate and Cadetship Network

Appendix A Summary list of enablers and barriers

A.1 Organisational factors

O1: Organisational readiness

O1.1 Board, executive and senior management support is evident

O1.2 Policies that support the employment of and ongoing career development for Aboriginal people:

- Host organisation acknowledges and supports trainees to fulfil cultural responsibilities
- Increasing the numbers of Aboriginal employees and ensuring they have ongoing career development and training opportunities is embedded in policy and practice.

O1.3 A culturally safe workplace is embedded in organisational leadership, governance and culture:

- Regular cultural awareness training is provided
- All staff are expected to work in a culturally competent manner
- Culturally inappropriate behaviour towards Aboriginal staff by patients and other staff is not tolerated
- All staff are responsible for the care of Aboriginal clients.

O1.4 Strong connections exist between the mainstream organisation and the local Aboriginal community:

- Support from local Aboriginal Elders is sought and nurtured
- Historical factors and Aboriginal cultural perceptions of health services are acknowledged
- Visible indications of an inclusive environment are evident
- The range of health employment options and career pathways available in the mainstream organisation are promoted in the community.

O2: Recipient recruitment is culturally appropriate and targeted

O2.1 Importance is placed on attracting suitable, job-ready trainees:

- Culturally appropriate forms of advertising are used
- Recruitment for traineeships is for positions that are needed
- Trainees are selected on the basis of their:
 - Match to role rather than being hurriedly identified and appointed when funding is secured
 - Performance during 'taster' programs
 - Prior experience in role and/or organisational familiarity, e.g. volunteer role.

O2.2 Culturally appropriate selection processes are in place for trainee recruitment:

- Aboriginal people on selection panel
- Informal interviewing environment
- Engagement of external agency staff who know the local community, to assist the organisation with recruitment.

O3: Recipient support provided by host organisation

O3.1 Person to person support:

- Mentoring
- Clinical supervision
- Support for trainees' personal circumstances
- Work-readiness support
- Peer support opportunities.

O3.2 Study support:

- Study leave that is not deducted from annual leave
- Additional support to address any literacy/numeracy or IT issues
- Access to appropriate study space (free from work demands).

O3.3 Engaging high-quality, supportive Registered Training Organisations (RTOs).

O4: Post-traineeship career development

O4.1 Employment opportunities available in the host organisation for externally recruited Program trainees:

- Reserving positions in the area of work in which the traineeship was completed
- 'Casual Pool' staffing, preferably with the allocation of a guaranteed number of work hours per week

O4.2 Opportunities exist for staff to up-skill through the Program

A.2 External factors

E1: Trainee characteristics

E1.1 Work-readiness

- Retention in the Program and in the health workforce generally is limited for trainees who are unable to meet the structured demands of working in the health system

E1.2 Literacy and numeracy skills

- Inadequate literacy and numeracy skills limits the opportunity for access to the Program and also for career advancement through further training

E1.3 Personal circumstances

- Adverse personal circumstances may impact the trainee's ability to complete their training or continue in their role and develop their career.

E2: Program design and administration

E2.1 Uncertainty about the timing of grants availability

E2.2 Lack of clarity about eligibility for grants, i.e. what funding could be used for:

- Program seen as primarily focussed on clinical roles. Perceived absence of grants for non-clinical roles seen as a key gap

E2.3 Career development limitations of Program:

- Program perceived focus on entry-level positions
- Further training needed for career advancement
- Lack of clarity for some trainees about career progression opportunities.

E3: Policy considerations

E3.1 Lack of surety about funding

This may make it difficult for organisations to:

- Plan their involvement in the Program
- Meet in-kind costs associated with supporting recipients through the Program
- Provide post-Program employment opportunities.

E3.2 Salary disparities between ACCHO and mainstream organisations

- Pay disparity and perceived better opportunities in mainstream organisations may lead to poaching of trained recipients from ACCHOs.

Appendix B Program background and implementation

This Appendix is set out under the following main headings:

- B.1 Conceptual factors related to workforce development
- B.2 The Victorian context
- B.2 Program history
- B.2 Traineeship program – Scope, study areas and uptake
- B.3 Program monitoring.

B.1 Conceptual factors related to workforce development

Workforce development

Workforce development encompasses a range of activities at various levels (system-wide, organisational and individual) in order to recruit new employees and retain existing staff by offering support and professional development opportunities (NSW Council of Social Services, 2007).

The ultimate goal of workforce development strategies is to build a capable and qualified workforce to meet the current and future needs of the community. This requires a broad model of workforce development, encompassing not only education and training to develop workers' knowledge and skills, but also organisational support strategies and workplace structures and policies which reduce potential barriers and encourage workforce participation (Roche, 2001).

Issues specific to Aboriginal health workforce development

The disparity between Indigenous and non-Indigenous participation in the health workforce is well documented (Mason 2013, Foxall 2013, DeLapp et al. 2008, Australian Health Ministers' Advisory Council (AHMAC) 2012). Reducing this disparity is consistently recognised as vital to all efforts aimed at addressing the serious health inequities faced by Indigenous populations worldwide (Curtis, Wikaire, Stokes, & Reid, 2012). A report from the Lowitja Institute notes that:

'[T]he ability of the health system to maintain high-quality standards of patient care emerges directly from the sector's ability to source, recognise, retain and reward appropriately-skilled labour – in this instance Aboriginal and Torres Strait Islander workers in health' (Bretherton, 2014, p. 1).

Evidence suggests that Indigenous populations face a unique constellation of challenges in 'commencing, continuing and completing' training or studies (Adams et al., 2005, p. 482). Curtis et al. (2012, p.2) noted that:

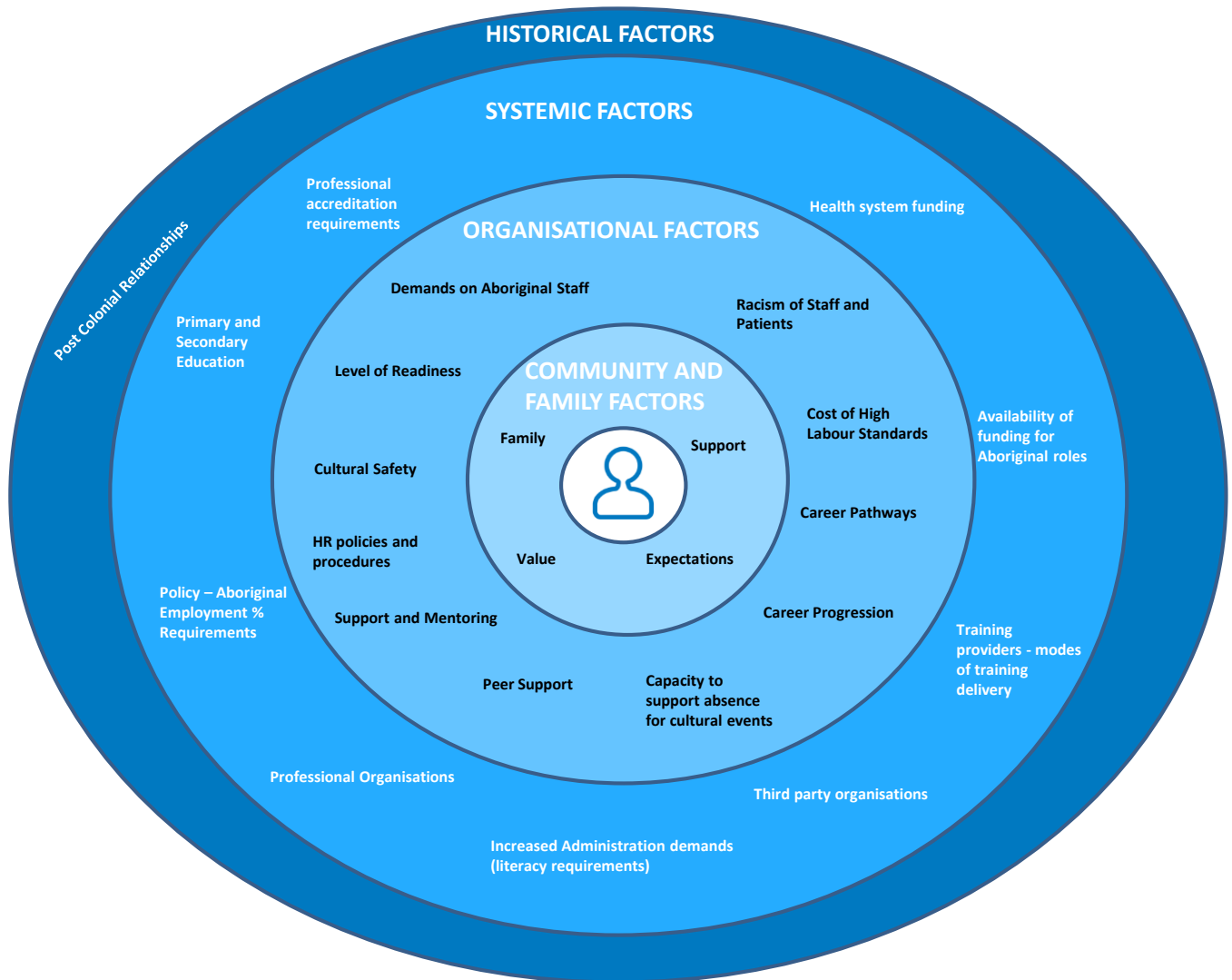
'There are multiple explanations for the shortage of Indigenous health professionals reflecting a mixture of supply and demand issues associated with historical, political, demographic, cultural, academic and financial factors.'

Consideration of barriers to the recruitment and retention of Indigenous people is therefore central to organisational strategies that aim to address the shortage of Indigenous health workers (Adams et al., 2005; Foxall, 2013).

Appendix B. Program background and implementation

As can be seen in *Figure B-1*, the factors are multifaceted and complex. The organisation's domain of influence does not cover all contributing elements which reinforces the need for cross-sectoral strategies as advocated in the literature. For example, work readiness is a key barrier to Aboriginal employment – whose responsibility is it to remedy this situation? Also, the literacy and numeracy requirements of roles especially those that lead to professional accreditation – can be a barrier that clearly intersects with the education/training sector illustrating the need for education and health sectors to work together.

Figure B-1: Contextual factors in Aboriginal workforce development



Defining success in the workforce development

Throughout the literature, differing definitions of 'success' are used in reference to recruitment, retention and employment outcomes for Aboriginal and Torres Strait Islander people.

Giddy et al. describe success for Aboriginal and Torres Strait Islander employment initiatives as those that 'lead to employment either directly or indirectly by overcoming barriers and creating pathways towards employment or further training' (2009, p.5).

The authors acknowledge that evaluating the success of initiatives must necessarily rely on a finite time frame to describe retention, and program policies may similarly define success as short-term retention.

Appendix B. Program background and implementation

They highlight the need for a longer-term, more holistic definition of success while acknowledging that short-term (non-sustainable) placements may nevertheless provide valuable stepping stones to future successful outcomes.

A 2006 report describes Aboriginal workforce participation as ‘initial engagement and ongoing retention in work that is mutually productive and satisfying for employer and employee’ (Purdie & Stone 2006, p. vii). Thinking of the success of the Program in terms of workforce participation as above is arguably a more useful definition of the desired outcomes than just the traditional meaning of ‘career’ in isolation. The vast majority of trainees surveyed and interviewed as part of this evaluation had/were undertaking Cert III or Cert IV level studies and many recipients had no intention of pursuing further studies. Most wanted to obtain a qualification in an area that meant they would be able to obtain ongoing employment.

B.2 The Victorian context

Aboriginal health workforce development in Victoria

The Victorian Government identified recruitment, retention and building a culturally responsive workforce as key commitments in *Victoria’s Aboriginal Recruitment and Retention Strategy 2010-2013* (Department of Human Services & Department of Health, 2013). The subsequent plan, *The Koolin Balit Aboriginal Health Workforce Plan 2014-17*, articulates Victoria’s health workforce development priorities and outlines a range of initiatives to increase and support the state’s Aboriginal health workforce. This plan will increase opportunities for Aboriginal people to enter or remain in the health workforce via a range of workforce development, recruitment and retention initiatives (Victorian Government Department of Health, 2014).

The government has allocated \$7.928 million over the four years covered by the plan to grow, upskill and better utilise the Aboriginal workforce (Victorian Government Department of Health, 2014).

Grant/traineeship funding has been provided to hospitals, Aboriginal Controlled Community Health Organisations (ACCHOs) and Community Health Centres (CHCs) through the Koolin Balit Training Grants Program.

Public-sector employment and career development outcomes for Aboriginal people were further supported by the Victorian Government’s Karreeta Yirramboi plan which was operational from 2010 – 2015. This plan set an Aboriginal employment target of one per cent for the Victorian public sector and required all public-sector organisations with 500 or more employees to develop an Aboriginal employment plan (The State Services Authority Victoria, 2011). The Victorian Public Sector Commission’s Aboriginal Employment Unit commenced work on a new Aboriginal Employment Strategy for implementation in 2017 (Victorian Public Sector Commission, 2010).

In partnership with the Commonwealth the Victorian Department of Health and Human Services has established 32 Aboriginal employment plans in Victorian Public Health Services. Funding through Koolin Balit supports the implementation of these plans as a key enabler to increase Aboriginal recruitment and retention. The Victorian Public Sector Commission has reported an increase in Aboriginal employment from 74 in 2011 to 211 in 2015.

Aboriginal population and workforce participation in Victoria

In 2011, there were approximately 37,991 Aboriginal people living in Victoria, representing 0.7% of the total Victorian population and 6.9% of the total Aboriginal population in Australia (Australian Bureau of Statistics, 2011a).

In Victoria in 2011, 12,000 Aboriginal people were employed. This represented a marginal increase from 11,900 in 2006. However, the increase in the Aboriginal labour force relative to the workforce in the interim years resulted in the Aboriginal unemployment rate in Victoria increasing from 10.3% in 2006 to 18.9% in 2011 (Australian Bureau of Statistics, 2006, 2011b).

Despite this increase in the unemployment rate, the number of Aboriginal people working in 'healthcare and social assistance' increased from 1,241 in 2006 (9.3% of the Aboriginal labour force in Victoria) to 1,716 in 2011 (11.6% of the Aboriginal labour force in Victoria) (Australian Bureau of Statistics, 2006, 2011b). This is encouraging, however the reasons for this increase in 'healthcare and social assistance' labour force are not known.

The Closing the Gap and Koolin Balit Training Grants

The Closing the Gap and Koolin Balit Training Grants Program (the Program) is a key Aboriginal workforce development initiative in Victoria.⁹ The Program provides grants for traineeships, cadetships and graduate funding to Health Services, ACCHOs and CHCs via:

- Closing the Health Gap initiative (financial years 2010-11, 2011-12, 2012-13)
- Koolin Balit funding (two rounds in 2013-14 and one in 2014-15).

The overall aim has remained the same throughout - to assist health services increase their capacity to support and provide training opportunities for their Aboriginal workforce.

The Program aims to:

- Provide opportunities for formal skills development for existing health service staff and/or new traineeships in management, nursing, allied health, dental, physical activity, primary health, alcohol, other drugs and mental health, personal care, health technician and health administration
- Position management training as an integral training component for the delivery of health and community services
- Assist health and community services to overcome financial burdens and barriers which prevent staff from taking up training
- Enhance a multidisciplinary team approach in primary care settings servicing Aboriginal communities
- Promote new trainee positions for Aboriginal people in the health sector
- Provide a career pathway for AHWs in health (Department of Health and Human Services, 2015).

⁹ "The Program" is also used in this report to include all support provided through cadetships and the INTRAIN scholarships.

Appendix B. Program background and implementation

Additionally, the INTRAIN (Indigenous Training and Recruitment Initiative) living allowance scholarship program was developed to assist Aboriginal tertiary students to study full time in the areas of human and community services. Since 2008-2009, 25 students have received funds to assist them to complete the last one or two years of a diploma, undergraduate or postgraduate course. The *INTRAIN Scholarship Evaluation Report* concludes that the INTRAIN scholarship program is achieving its objective of providing support to Aboriginal students so they may complete their studies in health, allied health and community services. At the time of the evaluation, 63% of scholarship recipients had gained employment in their field of study and 21% were still studying.

B.3 Program overview

The Program provides funding to health service organisations to support training and development through:

- **Traineeships** through which trainees undertake a range of courses in health. Organisations host trainees for the clinical component of their traineeship, while a Registered Training Organisation (RTO) deliver the formal education component. Traineeship courses are typically at certificate or diploma level. Some individuals were awarded more than one traineeship as they improved their qualifications.
- **Cadetship programs** for Aboriginal nursing, midwifery and allied health students, to support their induction into employment at health services (see *Appendix D*)
- **Graduate programs** which complement the above cadetship programs, by providing Aboriginal graduates with supported placements at health services (see *Appendix D*)
- **Grants** to fund development opportunities for existing staff, such as attendance at short courses (including cultural awareness seminars and workshops in mainstream health services) and interstate conferences (see *Appendix D*).

Traineeships are the main element of the Program and therefore the main focus of AHA's evaluation and the Final Report. Over the five years from July 2010 to June 2015, 313 traineeships were hosted by 63 organisations across Victoria (17 ACCHO and 46 mainstream organisations). *Section B.4* of this appendix provides additional details about the traineeship program.

Appendix D provides details of the cadetship, graduate and grant elements, including evaluation findings.

VACCHO's role

During the early stages of the Program (2009-10), VACCHO was funded to directly deliver training to upskill Aboriginal staff. This training included certificate-level courses and short courses for approximately 60 students, and spanned:

- Clinical upskilling courses for staff at ACCHOs
- Aboriginal Liaison Officer (ALO) course for staff based in hospitals.

VACCHO identified that the initial need in the Victorian Aboriginal community was to promote the role of Aboriginal Health Workers (AHW). At the time, there were AHWs in the Northern Territory who had a recognised profession, but this was not widespread in other parts of Australia. To address this need, VACCHO used an existing NSW AHW training program and implemented it in Victoria.

Appendix B. Program background and implementation

Practice management skills were also viewed as lacking amongst ACCHO staff, so Program funding was sought and received by VACCHO to implement a training program (composed of some clinical sections and practice management tuition) that lead to a Diploma of Practice Management. Initial take-up of this training was slow, and substantial time and effort was invested by organisations in making people aware of the availability of training. It quickly became apparent that many potential trainees did not have the capacity to submit an application to organisations.

To address this, a Certificate II was implemented in Warragul, providing a basic skills course as a prelude to further study. Recognising the difficulties some students experienced in getting to classes, a bus was provided to transport students.

In 2016, VACCHO reported that it is assessing the feasibility of introducing a Certificate II in Aboriginal Health Assistant traineeship, concentrating on non-clinical areas in the health workforce.

B.4 Traineeship program – Scope, study areas and uptake

Scope

Traineeships are available for Aboriginal and a limited number of non-Aboriginal staff, working in ACCHOs/ACCOs and in mainstream health services. Aboriginal people were prioritised for training grants. Trainees work at their host organisation for the clinical component of their traineeship, while a Registered Training Organisation (RTO) delivers the formal education component. Traineeship courses are typically at certificate or diploma level, however the Program also supported a number of higher education training that included nursing and dentistry.

Non-Aboriginal health staff who are involved in directly supervising Aboriginal staff, mostly undertake management and leadership traineeships under the Program.

The Program is open to trainees already employed by the host organisation and new recruits.

Host organisations can use traineeship funding for:

- Course fees, materials and study resources
- Mentoring and supervision support
- Paid study leave or to back-fill leave to cover staff attending training
- Accommodation and travel expenses
- To support the creation of new trainee positions within the organisation.

Since the 2014-15 EOIs, funding can also be used 'to support costs associated with assessment for Recognition of Prior Learning (RPL)'. In an attempt to address two recognised factors that impact the success of the Program (lack of work readiness and post-traineeship employment), the 2015-16 call for EOIs further defined the scope of the Program, as follows:

- 'It is recommended to undertake a pre-vocational/commitment work experience programs to assist the potential trainee with their decision. Contact your local learning and employment network for advice.'
- 'Priority will also be given to organisations able to demonstrate that they are able to offer ongoing employment on either a full time or part time basis.'

Study areas

Over time, the range of study areas that have been supported for trainees under the Program has increased, as shown in *Table B-1*.

Table B-1: Traineeship eligible study areas by year, 2011-12 to 2015-16

Study areas	2011 –12	2012 –13	2013 –14	2014 –15	2015 –016
Management + Leadership	✓	✓	✓	✓	✓
Nursing	✓	✓	✓	✓	✓
Allied Health	✓	✓	✓	✓	✓
Dental	✓	✓	✓	✓	✓
Physical Activity	-	✓	✓	✓	✓
AOD + Mental Health	-	✓	✓	✓	✓
Health Promotion	-	-	✓	✓	✓
Sexual Health	-	-	✓	-	-
Primary Health	-	-	✓	✓	✓
Personal Care Assistant	-	-	✓	✓	✓
Health Administration	-	-	✓	✓	✓
Health Technician	-	-	-	✓	✓
Health Assistants (Nursing)	-	-	-	-	✓

Most trainees receive only one traineeship, however a few received two and one received three traineeships. As shown in the above table, the range of eligible clinical areas has expanded. Non-clinical roles such as gardening and hospitality were not listed as eligible under the EOI submission specifications, but were eligible under the Program.

Uptake of Traineeships

In 2011-12, there were three rounds of assessment of expressions of interest (EOI) for organisations to receive Program funding to host traineeships. This decreased to two rounds per year in 2012-13 and 2013-14, and to one per year in 2014-15 and 2015-16.

Over the five years from July 2010 to June 2015, 313 traineeships were hosted by 63 organisations across Victoria. These 63 organisations comprised:

- 17 ACCHO organisations that hosted 128 traineeships (average 7.5 traineeships)
- 46 mainstream organisations that hosted 185 traineeships (average 4.0 traineeships).

The number of traineeships, by region, organisation type and year of commencement, is identified in *Table B-2*.

Table B-2: Traineeships by organisation type and region, 2010-11 to 2014-15¹⁰

Region	Mainstream organisation						ACCHOs						Grand Total
	2010-11	2010-11	2011-12	2012-13	2013-14	Total	2010-11	2011-12	2012-13	2013-14	2014-15	Total	
Barwon South West	1		2	9	2	14	11	4	2	7		24	38
Eastern Melbourne	1	2	4	6	7	20						-	20
Gippsland	6	12	13	13	6	50		2	1	3		6	56
Grampians	8	4		1		13	1	3	1	10	2	17	30
Hume			4	6		10	1	8	4			13	23
Loddon Mallee	3	6	2	5	2	18			10	8		18	36
North & West Metro	12	9	8	8	11	48	16	19	3	3		41	89
Southern Metro		5	4	1	2	12	1	2	6			9	21
Total	31	38	37	49	30	185	30	38	27	31	2	128	313

B.5 Program monitoring

Traineeship Program

Program monitoring is currently undertaken at the DHHS central office, with regional DHHS offices having variable amounts of engagement with the Program. Six-monthly reports are required to be submitted by host organisations for each of their traineeship recipients.

Host organisations reported finding the reporting process time consuming and it is not clear to them what benefit these reports provide for monitoring of the program. Several complained about having to wait for the final certificate to be issued to the trainee before a final report could be submitted

Three DHHS convened groups also have a role in monitoring the program:

- Victorian Expert Advisory Panel on Aboriginal Health
- Aboriginal Employment Advisory Group
- Project Officers Working Group.

Graduate and Cadetship Program

DHHS hosts regular meetings of the Aboriginal Graduate and Cadetship Network. The network is comprised of representatives from each health service involved in the Program and DHHS. These meetings provide the main monitoring undertaken for the Graduate and Cadetship Program. Additionally, DHHS provides funding for a 0.4 FTE position to coordinate the network.

¹⁰ The analysis presented is based on information provided by the Department. Some omissions and inconsistencies are apparent in this information and therefore, while the analysis provides a useful overview, its reliability for more detailed consideration is uncertain.

Appendix C Evaluation methods

Appendix C. Evaluation methods

This appendix summarises the evaluation methodology applied, set out under the following headings:

- C.1 Approach
- C.2 Data sources
- C.3 Recruitment strategy
- C.4 Data collection
- C.5 Data analysis
- C.6 Evaluability issues.

C.1 Approach

The evaluation was conducted using a mixed-methods approach with several sources of quantitative and qualitative data contributing to the evaluation findings.

Quantitative and qualitative data were analysed and triangulated to address the evaluation questions and provide a basis for findings.

C.2 Data sources

Data collection for the evaluation involved multiple information sources including DHHS, grant/traineeship recipients, peak bodies, host organisations and RTOs. *Table C-1* summarises the stakeholder groups and data collection methods used in the evaluation.

Table C-1: Stakeholder groups and data collection methods used

Stakeholder/source	Description of data collection method
Host organisations	Connection to recipients Face-to-face consultations (for case study sites only) Phone interviews Documentation relating to the Program Follow-up phone calls and emails to host organisations in Hume and Gippsland to establish and confirm trainee employment outcomes
RTOs	Phone interviews Face-to-face consultations (VACCHO)
DHHS Program developers and administrators Central and regional office staff	Face-to-face consultations Phone interviews Existing data sources: <ul style="list-style-type: none">• Training grants Program EOI – Submission Forms• Six-monthly grant progress report forms• Training grant final reports• Training grant case studies• INTRAIN Scholarships evaluation• Documentation related to the Aboriginal Cadetship and Graduate Programs• Detailed case study produced by Central Gippsland Health Services (CGHS)

Appendix C. Evaluation methods

Stakeholder/source	Description of data collection method
Grant and traineeship recipients	Survey Phone interviews Face to face consultations (for case study sites only)
Peak Bodies and Groups VACCHO CATSINaM Aboriginal Graduate and Cadetship Network	Face-to-face consultations Phone interviews Attendance at meetings
Site Visits Gippsland Hume Banyule CHC St Vincent's Hospital	Face-to-face consultations Phone interviews
Literature scan	A scan of Australian and international literature from 2005 to the present time

C.3 Recruitment strategy

A summary of the stakeholder recruitment approach utilised is presented in *Table C-2*.

Table C-2: Stakeholder recruitment approach

Stakeholders consulted	Organisations/methods which assisted in recruiting and contacting stakeholders			
	DHHS	Host organisations	Snowballing	AHA
Organisational representatives	✓			✓
Recipients		✓	✓	✓
RTOs	✓	✓		✓
VACCHO representatives	✓			✓
DHHS representatives	✓			✓

Host organisations were an engaged and helpful recruitment source. In many cases, they were able to contact trainees directly at their last available email address or phone number. A small number requested mail out information and one organisation provided AHA with email addresses and AHA emailed grant recipients on behalf of the host organisation.

AHA explained the need to contact as many people as possible and requested that if there were people they no longer had details for, if they could ask others to contact their past colleagues and let them know about the survey (snowballing). For several organisations, this method was successful in obtaining wider participation in the survey.

In one case, someone was located who knew a past recipient's mother. The mother was approached with material to give her daughter to encourage her participation in the evaluation.

Appendix C. Evaluation methods

Obtaining the support of RTOs to assist with the recruitment of trainees for the survey was not successful. Each RTO who had supervised Program trainees was emailed, along with an accompanying letter of support from DHHS. Fifteen RTOs were also subsequently contacted by telephone and seven were interviewed about general support services for Aboriginal and Torres Strait Islander students. These seven comprised a community college, two TAFEs – metro/rural and multi campus, three universities - regional and metropolitan, and a regional private RTO. However, all declined to assist in contacting traineeship recipients.

Social media

It was anticipated that social media platforms could be used by relevant host organisations, RTOs and ACCHOs to engage grant and traineeship recipients. A social media campaign could potentially encourage recruitment snowballing and target specific groups of recipients, to boost participation if required.

From initial contact with host organisations and RTOs, it was apparent that there was no appetite for this approach. It was seen as being ‘a lot of extra work to engage one or two people who may have left the organisation several years ago’.

However, organisations had good success in contacting the people connected to their organisation and were also willing to ask current employees to contact past trainees, i.e. using snowballing methods. For these reasons, the social media strategy was not applied further.

C.4 Data collection

Department of Health and Human Services

Collation of existing data sources

An initial review of existing Program documentation, data and reports held at DHHS central office was undertaken to ascertain their suitability to address the needs of the evaluation and to inform the development of the Project Plan and consultation tools. Considerable variability was evident in the quality and comprehensiveness of responses provided using the Department’s reporting template.

The following reports and documents were reviewed:

- Training grants Program EOI – Submission Forms
- Six-monthly grant progress report forms
- Training grant final reports
- Training grants case studies
- INTRAIN Scholarships evaluation
- Documentation related to the Aboriginal Cadetship and Graduate Programs
- Detailed case study produced by CGHS.

This information was also used to identify trends over time, and case study reports were analysed utilising narrative analysis and a cross-case generalisation of themes.

Consultations with DHHS Program developers/central office staff

Face-to-face consultations were undertaken with Program developers and implementation staff in the Aboriginal Health Workforce Branch at DHHS to obtain insights into the original vision and intended characteristics of the model, and their views on its implementation and future directions.

Consultations with DHHS regional staff

Discussions were undertaken and advice was sought from DHHS regional staff, particularly the Regional Aboriginal Health Partnership Officers, who work closely with the host organisations. Matters consulted about included:

- Mechanisms for accessing social media and other recruitment strategies
- Selection of site locations and contacts in Gippsland and Hume.

The regional staff provided updated information to assist with contacting the correct organisational representatives and in the site visit regions, insights into operational aspects of Program implementation.

Grant/traineeship recipients

Survey of grant/traineeship recipients

A survey was undertaken targeting all Program funding recipients. This provided a range of opinions about barriers and enablers that were gathered to inform the evaluation.

The survey:

- Identified key contextual factors such as recipient demographics, experience and education prior to the grant/traineeship
- Explored the recipient's experiences, motivations and expectations
- Identified the critical barriers and most significant enablers encountered for each of the groups.

The balance of question types is in line with the findings of the 2012 *New South Wales Aboriginal Workforce Study* where Likert scale questions were recommended to optimise the volume and quality of responses (Noetic Solutions, 2012).

Follow up in-depth telephone consultations with survey respondents

At the end of the grant and traineeship survey, respondents were invited to 'opt in' to being contacted by phone for further in-depth discussion about their traineeship and career experiences.

Phone or email contact was initiated by AHA with all respondents who opted in. The interviews were used to explore the impact of the grants/traineeship Program in more depth than was possible in the survey.

To facilitate recruitment of survey respondents for the follow-up interviews, a random prize draw of an iPad mini 2 16 GB was offered to all recipients who agreed to be contacted for further discussion. This draw was conducted in accordance with the Gambling Regulation Act 2003 and Gambling Regulations 2015 on 6 June 2016.

Appendix C. Evaluation methods

As well as interviewing grant traineeship recipients who had established a career in health, five people who had not established careers in health were interviewed to explore their career progression. As expected, few people from this cohort (not established careers in health) completed surveys, however host organisations assisted AHA to contact and interview these five people.

Peak bodies and groups

Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

Engagement with VACCHO was based on the organisation's three-fold capacity as a stakeholder in the evaluation:

1. As a conduit to grant/traineeship recipients: VACCHO's assistance was requested in sourcing grant/traineeship recipients who undertook training at VACCHO.
2. As a training provider: VACCHO were funded to deliver courses to grant/traineeship recipients. VACCHO's perspective as a training provider was sought at interview with the VACCHO CEO and Training Manager.
3. As the peak body for Aboriginal Health in Victoria: VACCHO provided high level commentary on its members' view of the Program and important insight into the future strategic direction needed to improve the employment of Aboriginal people working in health in Victoria.

Consultations were also undertaken with **CATSINaM** and **The Aboriginal Graduate and Cadetship Network**.

Host organisations

DHHS emailed each host organisation to introduce the evaluation and AHA. AHA then emailed the head of each organisation, explaining the evaluation and seeking permission to engage with others in the organisation. Some email responses were received, and telephone follow up was undertaken by AHA to increase organisational buy-in.

Host organisations had a dual role in the evaluation:

- As conduits to Program funding recipients:
 - Using Program information held by DHHS, each organisation was provided with a list of names of recipients and asked to forward notice of the survey to these individuals.
 - Where no contact details were available at the host organisation, AHA worked with the organisation to trace the individuals so contact could be made. Organisations were also asked to encourage participation and recruitment snowballing among recipients.
- By participating in the evaluation as:
 - Case study sites. Several organisations in the Gippsland and Hume regions as well as St Vincent's Hospital and Banyule Community Health participated in the evaluation as case study sites.
 - Non-case study sites. Twenty telephone/face-to-face interviews were conducted with current/former host organisations not subject to site visits.

Site visits

Four sites were selected by DHHS for site visit. Two of these locations were in Victorian rural/regional areas (Gippsland and Hume), one was a large city health service (St Vincent's Health) and the other, a large suburban CHC (Banyule). Multiple organisations were consulted during each visit to the rural/regional locations and a mix of organisational type (health service, ACCHO and CHC) were included.

The site visits provided an opportunity to obtain the views of different staff on the barriers and enablers related to the Program and the key factors that may help or hinder workforce development Programs more generally.

Site visits also provided:

- Opportunities to engage with stakeholders which lead to richer data because of the longer time frame it affords for building relationships and trust between the evaluators and the stakeholders
- Important contextual insights as the evaluators were able to see first-hand the environments in which grants/traineeships are delivered or where former recipients now work
- Access to current monitoring data and processes being undertaken by the organisation.

A range of stakeholders were invited to participate including:

- The CEO
- Senior managers
- Grant/traineeship managers/supervisors
- Other health workers and allied health team members
- Grant/traineeship recipients:
 - Current incumbents
 - Previous incumbents now employed by the organisation.

Each organisation made decisions about who would attend and representatives of all the above groups were able to have input into the evaluation in at least some of the site visit locations.

Prior to the visits, organisations were invited to provide any quantitative data they had for review. This information was sent to AHA after the interviews if not provided on, before or during the visit.

St Vincent's Health site visits resulted in consultation with seven members of staff- three members of staff with specific roles in AHWD in the hospital as well as management and trainees. At Banyule Community Health Service, AHA consulted with four team members; two managerial staff and two trainees.

Telephone consultations

A purposeful sample of organisations that were not included in the site visit schedule, were invited to participate in telephone interviews. Twenty consultations were undertaken to explore areas that had not been covered in site visits (e.g. smaller rural CHCs).

Appendix C. Evaluation methods

Interviewees included a mix of direct supervisors of grant and traineeship recipients, managers and executives in employing organisations. Again, the focus of these telephone consultations was on establishing the enablers and barriers to Aboriginal workforce development as experienced by employing organisations.

Training providers

All 28 RTOs, that had delivered elements of the Program at some stage, were contacted to obtain their input to the evaluation. Seven (25%) RTOs participated in interviews (refer *Appendix F*) comprising a community college, two TAFEs – metro/rural and multi campus, three universities - regional and metropolitan, and a regional private RTO.

Consultation was also undertaken with Monash Health, The Royal Women's Hospital and St Vincent's Hospital (cadetship and graduate Program sites) and Deakin University - Warrnambool (Nursing students only). As VACCHO is also a training provider, this aspect of their involvement in the Program was examined at the face-to-face interview conducted with members of the organisation.

A list of all organisations consulted is at *Appendix E*.

Literature scan

A scan of Australian and international literature from 2005 to the present time was undertaken to identify Aboriginal workforce strategies that have been effective in other jurisdictions, with particular emphasis on identifying strategies that are not currently available in Victoria. The scan concentrated on organisational barriers and enablers to Aboriginal people's employment in the health sector.

Findings from the literature scan were used to address Evaluation Question 4:

Are there strategies that have been effective in increasing Aboriginal people's employment in healthcare in other jurisdictions that are not currently available to Victorians?

C.5 Data analysis

The mixed method approach to the evaluation generated data from multiple sources that were synthesised, analysed and triangulated to assess the impacts of the grants and traineeships. The processes by which this was undertaken are described in the following sections.

Quantitative data

Quantitative data was systematically analysed to examine the impact of the grants and traineeship Program.

Qualitative data

A thematic analysis was undertaken of the qualitative data available from the Program monitoring information, surveys, site visits and telephone consultations using the three-stage approach to qualitative data analysis advocated by Miles, Huberman and Saldana (2013) (Miles, Huberman, & Saldana, 2013). This iterative thematic analysis was used to identify key themes and issues and to establish differences/commonalities within and across the various stakeholders involved in the Program.

Data triangulation

Findings from the quantitative and qualitative analysis were triangulated to address the evaluation questions. These triangulation processes facilitated the development of findings which have been used to provide advice to DHHS regarding the:

- Extent to which grant and traineeship recipients have established careers in the Victorian healthcare sector
- Critical enablers alongside the grant/traineeship for Aboriginal people who have established careers in mainstream organisations, such as hospitals, within the Victorian healthcare sector
- Most significant barriers experienced by people involved in the Program and particularly where successful careers in health have not been established
- Strategies that have been effective at increasing Aboriginal people's employment in healthcare in other jurisdictions that are not currently available in Victoria
- Recommendations on monitoring the impacts of grants and traineeships going forward.

In this analysis, particular emphasis was placed on the:

- Role of employing organisations in health workforce development
- Contextual factors at play in each case so that the Program can be assessed in terms of 'what works for whom in what circumstances, in what respects, and how' (Pawson & Tilley, 2011).

C.6 Evaluability issues

Evaluability is *'the extent to which an activity or project can be evaluated in a reliable and credible fashion'* (OECD, 2002). The key issues identified regarding the evaluability of the AHWD Program are summarised as follows:

- **Time lapse between training being undertaken and evaluation.** Some organisations and individuals were involved in training as part of the Program as long ago as 2009-10. In the intervening period, organisations experienced significant staff and structural changes (see below for implications thereof). These events highlight the dynamic environment in which the grants/traineeships were operating
- **Loss of corporate knowledge.** In some cases, key personnel involved in the Program had left the organisation and this resulted in a loss of corporate knowledge, particularly in relation to the development and implementation phases. The richness and depth of the information provided may have been compromised as a result
- **Recall bias.** It is well known that respondents may find it difficult to remember or accurately recall details that happened in the past. Research studies indicate that 20% of critical details are irretrievable after one year and 50% after 5 years (Hassan, n.d.). All studies that rely on self-reported data are prone to this limitation
- **Quality of evidence provided.** Considerable variability existed in the quality and quantity of information provided by organisations in their progress reports to DHHS, to indicate how the Program had been implemented in their organisation. Few engaged in formal evaluations of their initiative. This variability in evidence quality limited the comparability of innovations

between organisations and also the objectivity with which successes reported by individual organisations can be assessed

- **Methodological constraints.** Evaluation scope and budgetary constraints limited the number of in-depth consultations and site visits. Consequently there are limits on the extent to which comparisons can be made and findings generalised. Comparisons are therefore limited to organisation types which present the most useful illustration of different implementation strategies
- **Differences in how responses are articulated.** These differences may influence the interpretability of findings particularly as inclusion or exclusion of factors may relate to narrative style rather than reflect true differences between organisations. In the case of challenges, for example, it is likely that most organisations faced similar challenges but not all articulated these. The true scale of the challenges and facilitators reported by grant recipients may also be understated. For this reason, the discussion of enablers and barriers and outcomes list all factors included in the discussions and themes are not weighted in terms of the number of grant recipients who listed particular factors
- **Survey population and response rate.** Trainee organisations were tasked with sending the survey to trainees. Some were unsure how many surveys were distributed, and hence response rates could not be accurately determined
- **Survey respondents were those who could be contacted by organisations.** This feature leads to a bias in the survey data and interviews, as it is likely to be mainly people who are still engaged with the host organisation that were contactable.
- **Time lag time associated with data collection.** Information collected by the Department up to April 2016 was made available to the evaluation. However, at that time, the Department were not due to receive progress reports from host organisations for the period to December 2015. Consequently, more recent information was not available to this evaluation.

Appendix D Findings: Cadetships, graduates and grants

In addition to funding traineeships, Program funding is also provided to organisations to support:

- **Cadetship programs** for Aboriginal nursing, midwifery and allied health students, to support their induction into employment at health services
- **Graduate programs** which complement the above cadetship programs, by providing Aboriginal graduates with supported placements at health services
- **Grants** to fund development opportunities for existing staff, such as attendance at short courses (including cultural awareness seminars and workshops in mainstream health services) and interstate conferences.

This appendix provides details of the background, evaluation findings and barriers/enablers to these three components of the Program.

D.1 Cadetship and graduate programs

In 2013-14, the Victorian Government committed funds over four years for a workforce strategy that supports Aboriginal nursing, midwifery and allied health students through cadetship programs.

Koolin Balit, the Victorian Government strategic directions for Aboriginal Health 2012-2022, informed the development and funding of two complementary programs:

- Aboriginal Nursing, Midwifery and Allied Health Cadetship program
- Aboriginal Nursing and Midwifery Graduate program.

Cadetship program

The Aboriginal Nursing, Midwifery and Allied Health Cadetship program provides supported induction into employment at health services. The program objectives include:

- Increasing the number of Aboriginal nursing, midwifery and allied health students participating in the Aboriginal Nursing, Midwifery and Allied Health Cadetship Program
- Enabling opportunity for students to experience employment in a health service and develop professional and cultural networks
- Increasing the number of Victorian metropolitan, rural and regional health services delivering cadetship programs for Aboriginal nursing, midwifery and allied health students
- Providing a culturally safe workplace environment for the students
- Encouraging the successful transition of Aboriginal cadets into employment at either the employing health service or another health service
- Supporting best practice in patient care.

In 2013-14 and 2014-15, five health services supported 34 Aboriginal cadets. The Victorian Aboriginal Nursing, Midwifery and Allied Health Cadetship Program currently supports an additional 28 cadets at eight health services - St Vincent's Hospital, Monash Health, the Royal Women's Hospital, Latrobe Regional Hospital, Bendigo Health, Barwon Health, Eastern Health and Western Health.

An unpublished 2015 report provided by the Department found that, of 18 Aboriginal nurses and midwives who had participated in the program, 16 had continued employment in the relevant services, and the

Appendix D. Findings: Cadetships, graduates and grants

remaining two had returned to their communities to continue their health careers. Union figures suggest that in the general nursing population, 37% of new graduates cannot find a nursing position after graduation (Stewart, 2014).

According to the current Nurse and Midwife Graduate Handbook, Aboriginal nursing and midwifery graduates have, since 2014, obtained graduate positions at Austin Health, Barwon Health, Latrobe Regional Hospital, Monash Health, the Royal Women's Hospital and St. Vincent's Hospital Melbourne (Victorian Government Department of Health and Human Services, 2016).

Graduate program

Koolin Balit also informed the development and funding of the Aboriginal Nursing and Midwifery Graduate program, to complement the Cadetship program. The Graduate program objectives include:

- Increasing the number of Aboriginal nursing and midwifery graduates participating in the Aboriginal Nursing and Midwifery Graduate Program
- Enabling opportunity for Aboriginal graduates to participate in a graduate placement in a health service
- Increasing the number of Victorian metropolitan, rural and regional health services delivering graduate programs for Aboriginal nurses and midwives
- Providing a culturally safe workplace environment for the graduates
- Encouraging the successful transition to practice for Aboriginal nursing and midwifery graduates
- Supporting best practice in patient care.

In 2013-14 and 2014-15, four health services (St Vincent's Hospital, Monash Health, the Royal Women's Hospital and Latrobe Regional Hospital) supported 17 Aboriginal Nursing and Midwifery graduates. In 2015-16, participating health services will support up to 10 Aboriginal Nursing and Midwifery graduates.

An unpublished 2015 report provided by the Department found that, of 18 Aboriginal nurses and midwives who had participated in the program:

- 16 continued employment in the relevant services
- Two returned to their communities to continue their health careers.

According to the current Nurse and Midwife Graduate Handbook, Aboriginal nursing and midwifery graduates have, since 2014, obtained graduate positions at Austin Health, Barwon Health, Latrobe Regional Hospital, Monash Health, the Royal Women's Hospital and St. Vincent's Hospital Melbourne (Victorian Government Department of Health and Human Services, 2016).

Cadetship and Graduate program outcomes

The success of the cadetship program is evident in that:

- All cadets and graduate program recipients are still in the health workforce

All cadets and graduate program recipients are still working in health

- Of the 18 successful graduate Program students, all are still nursing and 7 of 18, (39%) were cadets. The network participants reported that Aboriginal nurses and midwives find the Programs improve their confidence and broaden their choices of jobs.

Enablers and barriers to program success

The Aboriginal Graduate and Cadetship Network meet regularly and is comprised of representatives from each health service involved in the Program and from DHHS.

The Network views the cadetships as a crucial mechanism for supporting people in the transition to university. Attracting cadets, and identifying eligible candidates in the universities, is a challenging task.

The network emphasises the need for:

- **A suitable position established to work with the universities** to ensure the Aboriginal support people/units within health services are aware of the AHWD Program. The current Full Time Equivalent (FTE) of 0.4 allocated to the network is insufficient to cover this aspect of the work. There is a perceived need to work together to establish a pool of cadets to rotate around in the health services which is currently being addressed by the existence of the network
- **Intensive work to be undertaken to engage the cadets.** If potential cadets do not commit to the Program when first approached, the coordinators in the organisations follow them up and try to convince them to be part of the Program for the next year
- **Mentor training** going forward
- **Clinical support** by culturally aware people coupled with Aboriginal mentorship
- **Peer support** to explore cultural identity and include it into professional life. This is currently undertaken as part of the study days.

At an organisational level, coordinators in the network noted that people 'notice a change in the cadets. They become more confident, their self-esteem grows.' One coordinator reported that one of her students 'even walks differently now.'

D.2 Grant recipients

Grants were used to fund development opportunities for staff. In some cases, this involved group training sessions, ranging in size from 'several' to 148 people. Information on the outcomes of these sessions was not available.

Seven respondents to the survey conducted for the evaluation, indicated that they had received funding to attend a short course as part of the Program. Of these, three were also recipients of traineeships, and four were exclusively short-course recipients.

These four short-course recipients were extremely positive about their experiences of the Program and the opportunities it afforded to them, however given the small sample size no conclusions could be drawn.

Appendix E Organisations consulted

E.1 Organisations consulted for the evaluation

Organisations consulted
Host organisations
Albury Wodonga Health
Alfred Health
Austin Health
Bairnsdale Regional Health Service
Ballarat & District Aboriginal Co-operative
Ballarat Health
Banyule Community Health
Bendigo Health
Castlemaine District Health Service
Central Gippsland Health Service
Community College Gippsland
Darebin Community Health
Dental Health Services Vic
Dhauwurd-Wurrung Elderly and CHS
Eastern Health
Gateway Health
Gippsland and East Gippsland Aboriginal Co-Operative
Gippsland Lakes Community Health
Latrobe Community Health Service
Latrobe Regional Hospital
Melbourne Health
Monash Health
Rumbalara Aboriginal Cooperative
St Vincent's Hospital
Swan Hill District Health
The Royal Women's Hospital
Victorian Aboriginal Health Service
West Gippsland Healthcare Group
Western Health
Winda-Mara Aboriginal Co-operative
Peak bodies
Aboriginal Graduate and Cadetship Network
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)

Organisations consulted

Victorian Aboriginal Community Controlled Health Organisation (VACCHO)

Training providers

Advance TAFE

Riverina Institute of TAFE

Ballarat University

Charles Sturt University

RMIT University

Australian Institute of Flexible Learning

Community College Gippsland

Other stakeholders

Department of Health and Human Services

La Trobe City Council

**Appendix F Review of Aboriginal health
workforce development strategies
outside Victoria**

This appendix is set out under the following main headings:

- F.1 Conceptual frameworks for Aboriginal health workforce development
- F.2 Australian policy environment and government Aboriginal health workforce strategies
- F.3 Initiatives to increase recruitment and retention.

F.1 Conceptual frameworks for Aboriginal health workforce development

A number of broad factors that contribute to successful Aboriginal and Torres Strait Islander health workforce outcomes have been described in the literature. These represent ‘themes’ that may be helpful in overcoming the numerous barriers to Aboriginal health workforce recruitment and retention (both supply- and demand-side) and contribute to the development of context-specific strategies such as those described in the next section.

Many of the enablers identified in the literature involve organisational support of the individual to attract and retain them as staff. In this way, they technically target supply – that is the number of Aboriginal health professionals who are able and *willing* to meet organisational demand. However, identified enablers underpinning the Koolin Balit Aboriginal workforce plan 2014-2017 include demand-side factors, such as cultural respect, a holistic approach, health sector responsibility, local and state/territory decision making, building the capacity of health services and communities, partnerships and coordination in policy development, planning, implementation, monitoring and evaluation and accountability mechanisms (Victorian Government Department of Health, 2014).

Not surprisingly, the literature suggests that *‘the recruitment and retention of Indigenous students into medicine and other health science careers is a complex task that involves simultaneous or sequential tasks by a number of sectors, agencies and individuals’* (Chesters et al., 2009). It is therefore useful to consider individual enablers of Aboriginal workforce development as components of a more holistic approach, as both supply and demand side barriers must be addressed by policy makers, educational institutions, employers, professional organisations and other stakeholders in order to facilitate better outcomes (Bretherton, 2014).

The ‘Principles Framework’ described by Social Ventures Australia describes both personal and community infrastructure enablers to tackling youth unemployment, although the authors note that they are relevant ‘across many different at-risk groups and for those experiencing complex barriers’ (Social Ventures Australia 2016, p. 13):

- Personal principles (people are ready to work)
 - Identity (e.g. confidence, presence of positive role models)
 - Building aspirations
 - Literacy and numeracy capability
 - Employability skills
 - Careers management
- Community infrastructure (collaboration to deliver employment solutions)

Appendix F. Review of Aboriginal health workforce development strategies outside Victoria

- Business partnerships
- Early intervention
- Personalised support
- Alternative employment pathways
- Financial support.

Curtis et al. (2012) suggested using a ‘pipeline’ framework to conceptualise health recruitment and retention activities. These authors cited the Sullivan Commission report, which noted:

‘a pipeline from primary to secondary to postsecondary education, and finally to professional training, channels the flow of a diverse and talented stream of individuals into the nation’s health care workforce’ (Curtis et al. 2012, p.2)

There has been a plethora of strategies aimed at increasing Aboriginal participation in the health workforce that have been implemented at various stages of the ‘pipeline’, and these can be categorised according to the context in which they were implemented (see *Table F-1*). Conceptualising recruitment and retention activities using the pipeline framework allows for a more holistic identification of the barriers and enablers to Aboriginal people’s participation in the health workforce.

Table F-1: Curtis et al.’s (2012) five broad contexts for workforce development strategies

Context	Definition
Early exposure	‘Activities targeted towards secondary school students that aim to expose students to health careers and academic pathways’
Transitioning	‘Activities that assist secondary school students to enter tertiary study programmes’
Retention/completion	‘Activities that aim to support success in tertiary health professional programmes’
Professional workforce development	‘Activities that aim to develop the existing health workforce including continuous professional development, specialisation or career development’
Across the total pipeline	‘Activities that occur in more than one aspect of the pipeline’

Addressing the broader chronological approach (the ‘pipeline’) will be most relevant to policy makers with the ability to contribute to the continuum from early education through to professional development. Indeed, national initiatives and policies acknowledge the spectrum across which the Aboriginal health workforce can be bolstered and supported (National Aboriginal and Torres Strait Islander Health Council, 2008; *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011-2015*, 2011) and it has been noted, for example, that skill development on its own does not necessarily lead to career development (Bretherton, 2014).

While effective strategies for improving AHWD can be considered in a chronological context, they are also multi-sectoral. Bretherton (2014) describes five interrelating contexts in which to consider Aboriginal and Torres Strait Islander health career development: policy frameworks, workplace processes, intermediary behaviour (e.g. involving education and training and employment agencies), individual characteristics and

professional association interventions. Given the complexity of these issues across time and context, the importance of partnerships between sectors and communities has been emphasised (Western Australian State Government Department of Training and Workforce Development, 2010).

F.2 Australian policy environment and government Aboriginal health workforce strategies

Under the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011-2015, Australian states and territories have developed jurisdictional Aboriginal and Torres Strait Islander health workforce strategies and action plans, with the Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG) providing a forum for information sharing and cross-jurisdictional learnings (*National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011-2015*, 2011).

The first two key priority areas articulated in this strategy were:

- Increased numbers and proportions of Aboriginal and Torres Strait Islander peoples working across all the health professions achieved through appropriate education, training, recruitment and retention strategies
- Effective training, recruitment and retention of Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander health staff in Aboriginal and Torres Strait Islander community-controlled health services.

At the national level, a number of scholarships are available (e.g. Puggy Hunter Memorial Scholarship, Nursing and Allied Health Scholarship and Support Scheme) to assist in bolstering the Aboriginal health workforce, and the Australian Government's Health Heroes campaign is designed to encourage Aboriginal secondary school students to pursue a health career. This initiative includes a website with resources for students, jobseekers, teachers and parents (Australian Government Department of Health and Ageing, n.d.). The Aboriginal and Torres Strait Islander Health Performance Framework 2014 report suggested that the campaign had reached 36% of the target audience, who may have explored a potential health career by speaking with a counsellor, parent or teacher (Australian Government Department of Prime Minister and Cabinet, 2014a). In single jurisdictions (other than Victoria), a number of policies and initiatives are apparent, as outlined below. These sit within the context of numerous other relevant policies, programs and initiatives targeting Aboriginal education and economic participation more broadly.

Queensland

The Queensland government's 'Making Tracks' policy notes that 'career pathways for Aboriginal and Torres Strait Islander health staff and strategies for encouraging greater participation of Aboriginal Australians in the health workforce is an ongoing priority'(Queensland Health 2010, p.22).

The Queensland Health Aboriginal and Torres Strait Islander Workforce Strategy aimed to improve recruitment and retention of Aboriginal staff across all occupational streams, recognising in particular the roles of support and professional development in successful outcomes. Strategies identified included clarification, recognition and enhancement of AHWs and liaison officers, review of human resource policies for Aboriginal staff. In addition, an Aboriginal and Torres Strait Islander Staff Network was established to promote the engagement, participation and advancement of Aboriginal and Torres Strait Islander staff,

Appendix F. Review of Aboriginal health workforce development strategies outside Victoria

provide a forum for exchange of information, build and share practical knowledge and strengthen linkages and engagement across the organisation (Queensland Health, 2010b).

Workforce development initiatives have also been undertaken by the Queensland Aboriginal and Islander Health Council (Queensland Aboriginal and Islander Health Council, n.d.).

New South Wales

The most recent NSW Aboriginal Workforce Strategic Framework has been reviewed and is in the process of being updated. The previous framework highlighted key priorities of increasing representation of Aboriginal employees (in the health sector as a whole and across all professions), develop partnerships, provide leadership and planning, tap into increasing numbers of Aboriginal university graduates in health areas, and provide culturally safe and competent health. These priorities, and the outcomes identified, are supported by action plans within each local health district and other organisations services (NSW Government Ministry of Health, 2011).

The NSW Ministry of Health website outlines a number of traineeships, cadetships, scholarships and career pathways, and the Stepping Up website provides recruitment information and resources for both jobseekers and potential employers (NSW Ministry of Health, n.d.).

A series of newsletters highlight the range of initiatives being undertaken across the state to develop the Aboriginal health workforce, including workshops and work experience programs for secondary students, employer-specific training programs and organisational cultural safety training (NSW Government Health, n.d.).

South Australia

The most recent South Australian Aboriginal Health Workforce Strategy (2009-2013) identified six priority areas: systemic reform, engagement (including with communities and across relevant sectors), attraction and recruitment, retention, Aboriginal leadership and development and monitoring and reporting (SA Health, 2009).

The South Australian Aboriginal Health Partnership (a partnership between the state Department of Health, the Commonwealth Department of Health and Ageing and the Aboriginal Health Council of SA) works collaboratively on key areas related to Aboriginal health, including workforce development.

ACT

ACT Health's Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013-2018 includes the objective of providing programmes for Aboriginal and Torres Strait Islander peoples and employees that support development, education and training opportunities in the health care sector (ACT Health, 2008).

The ACT Health website contains information about Enrolled Aboriginal and Torres Strait Islander Nursing Scholarships (ACT Government Health, n.d.).

Western Australia

WA's Aboriginal workforce development strategy identifies five key themes for action:

- Connecting employers with Aboriginal job seekers to meet growing work opportunities
- Engaging local knowledge and capacity to achieve successful regional Aboriginal employment outcomes
- Improving the transitioning of Aboriginal people to achieve sustained employment outcomes
- Removing barriers to participation in the workforce
- Raising awareness of Aboriginal employment opportunities and promoting new Aboriginal role models (Western Australian State Government Department of Training and Workforce Development, 2010).

The Government Department of Training and Workforce Development has established Aboriginal Workforce Development Centres (AWDCs) to help Aboriginal people access training, find employment and/or further their careers, as well as support employers to make workplaces and practices more culturally sensitive (Government of WA Department of Training and Workforce Development, n.d.). Services for job seekers include 'encouraging the development of employability skills for successful participation in the workforce' and access to role models and mentoring services. Aboriginal Training and Employment Services operate in areas of the state where an AWDC has not been established.

Northern Territory

The Northern Territory's Aboriginal Health and Community Services Workforce Planning and Development Strategy 2012 – 2022 highlights the importance of partnerships and collaborations in various health workforce segments (Human Services Advisory Council inc, n.d.). Strategic statements have been developed to guide workforce development activities within each segment.

The NT Department of Health supports the Indigenous Cadetship Support program, available to provide tertiary students with work experience opportunities and mentorship throughout their study.

Tasmania

A 2013 discussion paper released by DHHS highlighted the importance of the following areas:

- Improving workforce data reporting and analysis to determine gaps and needs
- Engaging with the key state and national bodies to assist in the development of workforce strategies
- Working with the education sector to increase pathways and linkages to the health workforce to enable Aboriginal workers to work within their own communities and create pathways to employment across all service delivery sectors
- Developing a broader understanding of Aboriginal and Torres Strait Islander culture and cultural competency within the mainstream health workforce (Tasmanian Government Department of Health and Human Services 2013).

The Department offers the Ida West Scholarship scheme for Aboriginal students in health and human services disciplines (Tasmanian Government Department of Health and Human Services, n.d.).

F.3 Initiatives to increase recruitment and retention

A number of specific strategies and programs for recruitment and retention of Aboriginal and Torres Strait Islander staff have been described in published and grey literature. This section highlights some of these to illustrate how the barriers and enablers described above have informed the implementation of strategies to improve Aboriginal health workforce recruitment and retention.

It is important to note that policy-makers and organisations have the ability to address both demand-side (i.e. institutional/organisational) and some supply-side (i.e. individual) barriers to recruitment and retention. For example, financial support, exposure, support with transitioning to tertiary study and mentoring initiatives can assist in overcoming supply-side challenges. Improving cultural safety within educational/training organisations and workplaces is a clear strategy for addressing demand-side barriers and improving Aboriginal health workforce outcomes (although it also impacts on the supply of Aboriginal and Torres Strait Islander people willing and able to take and retain positions within a given organisation).

Increasing demand

At the broadest level, increasing demand for Aboriginal healthcare workers requires an organisation that values and supports the recruitment and retention of Aboriginal staff. In recent years, Commonwealth and state and territory governments, sectors and individual organisations have introduced targets for Aboriginal representation in various workforces. For example, the Commonwealth public sector is currently aiming for 3% Aboriginal and Torres Strait Islander representation by 2018, the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework stated an 'aspirational' target of 2.6% by 2015 (*National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011-2015*, 2011), and the Victorian public sector (encompassing the public health sector within the state) targeted 1% by 2015 (Victorian Public Sector Commission, 2010).

Initiatives such as the *Long term unemployed and Indigenous wage subsidy* (Australian Government Department of Employment, 2016) and *Tailored Assistance Employment Grants* (Australian Government Department of Prime Minister and Cabinet, n.d.) can provide financial incentives for organisations to boost their Aboriginal workforce, creating demand.

Most states and territories have their own Aboriginal employment frameworks, strategies and policies within one or more sectors including health, public service and local government. In the private sector, the Australian Employment Covenant aims to have private employers commit to providing 50,000 jobs for Aboriginal people, along with tailored training packages and workplace mentors, to contribute to the Closing the Gap initiative. However, while initial private sector 'buy in' was promising (in terms of jobs promised), it is unclear to what extent the covenant has been successful in facilitating private and public sector collaboration to increase Aboriginal employment (Department of Education, 2013).

Increasing supply

A number of strategies have been implemented in a variety of contexts to overcome barriers to Aboriginal people's participation in the health workforce from pre-recruitment through to ongoing professional

Appendix F. Review of Aboriginal health workforce development strategies outside Victoria

development. This section outlines strategies to increase the number of Aboriginal people suitably qualified for a position within the health workforce, requiring individuals to be recruited into and retained in training/study courses to completion.

Early exposure

Key strategies to promote Aboriginal recruitment at the early exposure stage of the pipeline that will be discussed in this section include:

- Provision of effective career advice to Aboriginal students
- Exposure to science, maths, and English subjects at school
- The importance of role models
- Exposure to the health sector via ‘taster courses’, work experience etc.
- The importance of creating ‘true partnerships’ and linkages between providers, universities and the community.

Career development advice is an important resource, particularly for school age children and young adults. The provision of targeted, effective career advice to Aboriginal students is especially important because it has the potential to encourage these students to explore health careers and support them through the process of choosing and applying for tertiary training/study. Chesters et al. (2009) suggested that career advice should be ‘delivered in culturally sensitive and informed ways’ that is centred on the individual – their skills and abilities as well as their aspirations and worldview.

The same authors found evidence that Victorian school careers counsellors were not well equipped to provide effective and culturally appropriate advice to Aboriginal students, and suggested that career development practitioners require access to professional development and cultural competence training to better equip them with the necessary skills to provide high quality career advice to Aboriginal students. They also suggested that career advice and guidance should ideally commence in primary rather than secondary school because career aspirations begin well before secondary school.

Many authors echoed Chesters et al.’s (2009) suggestion to market career advice to younger students, (albeit with a focus on secondary school students). For example, DeLapp et al. (2008) described an initiative in Alaska designed to increase the recruitment of Indigenous nursing students into the University of Alaska Anchorage (Project RRANN). The first phase of this initiative involved marketing nursing education and careers to high school students in the form of advertising material, recruitment trips to high schools and careers fairs across Alaska.

Curtis et al. (2012) proposed that interventions at the early exposure stage should encourage Aboriginal secondary school students to undertake the necessary prerequisite subjects at school (science, English, mathematics) in order to reduce the gap in educational attainment often faced by Aboriginal candidates for health training/study programmes (Foxall, 2013). In a series of recommendations for Aboriginal health workforce development, the National Aboriginal and Torres Strait Islander Health Council (2008) identified a need for government funding for the improvement of Aboriginal mathematics, science and literacy programs. They also recommended that tailored careers guidance and role models need to be made available to Aboriginal students.

Appendix F. Review of Aboriginal health workforce development strategies outside Victoria

In addition to effective career advice and role models, exposing Aboriginal students to the tertiary environment early may also bridge the gap in knowledge about career and training opportunities and foster 'student confidence and motivation to apply for health programmes' (Curtis et al., 2012). Though these authors referred to the university context specifically, this strategy for enabling Aboriginal recruitment into the health workforce is arguably also applicable to other training and employment opportunities.

For example, in their evaluation of the ACIMH program (coordinated by the Mental Health Coordinating Council (MHCC)) in NSW, EJD Consulting and Associates (2014) cited the MHCC's suggestions to employers seeking suitable trainees. These suggestions included a pre-employment course of 3-4 weeks provided by the employer to potential candidates which would allow both sides to assess their suitability for participating in the ACIMH program and/or a 2-3 day 'taster' course designed to introduce potential candidates to the mental health workforce and the workplace.

Sutton et al. (2012) conducted an evaluation of The Vacation School Project – a pilot program in Gippsland that was designed to expose allied health and nursing students studying in Melbourne, to mental health employment opportunities in the Gippsland region. This program aimed at increasing the rural mental health workforce in Gippsland and included five days of seminar presentations, site visits to mental health providers in Gippsland, plenary discussions and social events.

The preliminary findings from this evaluation suggested that the project positively affected participants' 'level of interest' in working in a rural environment, mental health, and a rural mental health environment specifically. Though no Aboriginal students participated in this pilot project, this model of exposing students (or trainees) to different health sector settings as a way of guiding career choices demonstrated positive results.

Similarly, the National Native American Youth Initiative targeted American Indian and Alaskan Native high school students. The Program aimed to prepare participants for tertiary study and promote careers in health and biomedical research through a series of lectures, workshops and field trips. A large proportion of participants in the Program went on to higher education, with many pursuing qualifications in health related fields (Australian Indigenous Doctors' Association, 2010).

The final key theme that emerged from the literature regarding early exposure strategies relates to the creation of 'true partnerships' and linkages between providers, universities and the community to promote 'health workforce culture' and involve Aboriginal communities in the workforce development process (West et al. 2011, Miller 2005, EJD Consulting and Associates 2014, DeLapp et al. 2008). The success of this strategy is demonstrated by the Tjirtamai Model implemented in Queensland that '*established a 'culture' of Aboriginal nursing in the community, role modelling nursing as a very achievable career pathway (for Aboriginal people)*' (West et al., 2011, p. 43). See Figure F-1 case study 1, for further detail of the Tjirtamai Model.

Transitioning

Key strategies to promote Aboriginal recruitment at the transitioning stage of the pipeline that will be discussed in this section include:

- Bridging courses to increase academic preparedness for training/study
- Assistance with the transition from school to study/training

Appendix F. Review of Aboriginal health workforce development strategies outside Victoria

- Pre-employment training initiatives (preparing individuals for the workplace) and ‘work hardening’.

The Tjirtamai Model (see *Figure F-1 case study 1*) demonstrates some transitioning strategies that are useful in overcoming barriers faced by Aboriginal people. In particular, the Tjirtamai model provides an example of the ways bridging courses enable Aboriginal students to overcome any gaps in their educational attainment and preparedness for tertiary training/study. A similar strategy has also been implemented in New Zealand at the University of Auckland as part of their Vision 20:20 program designed to improve Indigenous health workforce participation by recruiting suitable students into tertiary study and supporting them to complete their course (Curtis & Reid, 2013).

A key component of the Vision 20:20 program is the delivery of a one year foundation program that prepares Indigenous students for entry into health science undergraduate degrees (such as nursing, pharmacy and health science (pathway to medicine)). This foundation program is delivered as a Certificate in Health Sciences (CertHSc) and includes Maori and Pacific content and methods in the curriculum and non-lecture-based teaching methods (tutorials). As a result of the Vision 20:20 program (which involves targeted recruitment activities, admission, retention, academic and pastoral support in addition to the CertHSc), Curtis & Reid noted that the student pass rate within the Faculty of Medical and Health Sciences for Maori and Pacific students increased from 89% and 81% respectively in 2005 to 94% and 87% in 2011.

Both the Tjirtamai Model (West et al., 2011) and the Vision 20:20 program (Curtis & Reid, 2013) provided further transitioning support to Indigenous students. These support strategies included administrative assistance with student applications (to tertiary institutions, and for scholarships etc.) and family and community involvement in the application and learning processes. These strategies were viewed as important to supporting Indigenous students in their transition to tertiary study/training to ensure the recruitment phase of beginning a health program was as uncomplicated and smooth as possible.

Another approach to assist with the transition from school to work involves school-based initiatives: for example, training programs delivered in school settings, school-based apprenticeships and traineeships and structured work placements (Northern Territory Aboriginal Health and Community Services Workforce Planning and Development Strategy 2012, 2012). However, although numbers are low, such programs showed limited promise in the Northern Territory, with too few RTOs and schools engaged (particularly in health and community services settings) and low completion rates for Aboriginal and Torres Strait Islander students.

In the context of the workplace, a recent poll found that 47% of Indigenous respondents perceived that ‘not having a good understanding of the formal and informal rules of the workplace’ was a barrier to their employment (*Community attitudes to Indigenous education, training and employment*, 2011). Generic skill development (e.g. literacy and numeracy, communication and teamwork skills) is also important for career development, not only facilitating an initial employment opportunity but also confirming longer-term employability (Bretherton, 2014).

In an attempt to overcome these barriers, ‘work readiness’ and ‘pre-employment’ programs have been described in various contexts. While the terminology is not consistent, the former is often a generic program designed to help individuals to develop ‘soft skills’, boost confidence and self-esteem, and may include money management, literacy and numeracy, cultural awareness and job search training. Pre-employment programs, on the other hand, are generally directly linked to an industry, and, potentially, to

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an employment position at the end of training (Aboriginal Workforce Development Centre, n.d.). Although not health sector specific, success criteria related to program reach, program design and content, program relevance, program delivery, post-program support and program improvement has been described in the literature (Aboriginal Workforce Development Centre, n.d.).

Support through all major transitions (school to training, training to employment and unemployment to the workforce) is important, with the WA Aboriginal workforce development strategy noting that ‘relationship-based mentoring is the critical ingredient in helping individuals to make successful transitions into sustainable employment’ (Western Australian State Government Department of Training and Workforce Development 2010, p.3).

Pre-employment initiatives for Aboriginal job seekers

Ganbina – Shepparton

While not health workforce specific, Ganbina works with Aboriginal youth (from primary school until the age of 25), delivering programs that help with educational attainment, exploring career options, developing life skills and transitioning from study into ‘meaningful, sustained employment’.

Analysis of the Program showed that it provided considerable social return on investment, with individuals benefiting from increased aspirations and motivations, better access to job opportunities and the resources required to participate in education and the workforce (Social Ventures Australia, 2016).

Financial and personal support

The financial implications of study and training is a clear barrier to initial recruitment into a course of study, and financial assistance (through stipends, scholarships, housing assistance, childcare etc.) is an obvious enabler, particularly where individuals must live out of home/community (DeLapp et al., 2008; Foxall, 2013; West et al., 2011).

In many cases, financial assistance is one component of a more holistic support ‘package’ aimed at retention of students through a course of study. For example, Alaska’s Project RRANN involved the opportunity for Indigenous students to qualify for a monthly stipend during their studies (DeLapp et al., 2008). However, the central component of Project RRANN was the Nightingale Wing, established in the University of Alaska Anchorage dormitories as a nursing residence hall specifically for use by RRANN (Indigenous) and other nursing students.

This wing assisted in reducing feelings of isolation and homesickness felt by Indigenous students (and non-Indigenous students) who had moved away from their homes and communities to study. It also offered the chance for increased peer support, access to role models (older students, resident advisors and RRANN staff), and was the site of RRANN meetings and academic support activities (including tutorials and mentoring).

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DeLapp et al. (2008) described Project RRANN as having demonstrable success in increasing the number of Indigenous graduates since its establishment in 1998 and stated that it had improved the experience of Indigenous students through their tertiary studies as evidenced by positive student testimonials. Whilst the RRANN model demonstrates the success of a program designed to provide support for students away from their homes, other models have been designed and implemented within Aboriginal communities to reduce the isolation from family/community and to increase the likelihood of growing the local health workforce. An example of this (**the Tjirtamai Model**) is provided in the following case study (*Figure F-1*).

Figure F-1: Case study 1 - The Tjirtamai Model

Background¹¹

In 2009 in a rural and remote town in Queensland, an Aboriginal Community Controlled Health Service (ACCHS) and a RTO partnered to deliver a Certificate III in Health Services Assistance (Assistant in Nursing) (the town and ACCHS were not specified by West et al.). The service delivery model became known as the Tjirtamai ('to care for') Model.

This model was designed and delivered by Aboriginal health workers (primarily nurses) working in the community and the students were all local Aboriginal people interested in becoming nurses. The need for this pre-entry nursing course was identified when a number of local Aboriginal people presented to the ACCHS to request information regarding nursing training courses.

A consultant was hired to source funding opportunities and explore pathways from an Aboriginal nursing course into a VET Diploma of Nursing, a Bachelor of Nursing or other employment options upon course completion. The Tjirtamai program was designed as a bridging course to prepare local Aboriginal students for tertiary training/study whilst also providing a qualification that would allow graduates who did not wish to move onto further training or study to work as Nursing Assistants.

This program was both developed and implemented by Aboriginal community members who were familiar with the challenges of tertiary health training/study faced by Aboriginal people. These program leaders based the course design on their observed need *'to deliver a community based culturally appropriate nursing education and pre-entry model specifically designed for rural and remote students'* (West et al. 2011, p.42). Moreover, in the region where this course was delivered, Aboriginal nurses and health workers were severely underrepresented in the Nursing workforce – though 27.3% of the regional population were Aboriginal people, less than three percent of the nursing workforce identified as such.

Thus, the rationale for this course centred on the likelihood of students remaining in the area to work as nurses or nursing assistants (since they were born and raised there), thereby closing this gap in the local health workforce.

Service delivery model

The model included funding to provide assistance with:

- Childcare, housing, transport and meals
- Development of literacy and numeracy skills
- Application processes including University applications, Blue Card applications (Working with Children checks), Australia Federal Police Check, scholarships
- Education regarding the need for Hepatitis B Vaccination.

¹¹ (West et al., 2011)

A similar initiative was implemented on Thursday Island in the Torres Strait in 2003 (Usher et al., 2005), with JCU School of Nursing establishing a satellite campus to deliver an undergraduate nursing program to local students. The course was delivered with the same content as the mainland program but in a different format – tutorials were delivered on site and students also attended a one-week intensive block of training at the JCU Townsville campus. A local senior nurse was appointed the senior lecturer and the majority of the course was delivered by locals. This effectively created an atmosphere of community ownership and acceptance of the course and provided local role models for students (the gap in English language proficiency was also mitigated by the appointment of local people). Importantly, the Thursday Island campus was well equipped and provided a safe environment for students to study and support each other.

Once employed, personal support can be provided through a range of strategies including mentorship and flexible workplace policies. These are discussed further in the following sections.

Mentoring/role modelling

As described earlier in the context of the RRANN and Thursday Island projects, role models and mentors can be powerful enablers to Indigenous recruitment.

The importance of role models emerged as a fundamental component of strategies to increase Aboriginal peoples' exposure to both health careers and examples of the opportunities available through tertiary training/study. In their review of South Australia's Pika Wiya Learning Centre, Adams et al. (2005) stated that the Centre developed Aboriginal students' aspirations in part by providing strong role models (centre staff, peers, former students). Similarly, part of the success of Project RRANN (DeLapp et al., 2008) was the use of Alaska Native/American Indian nursing students in the recruitment activities targeting high school students. These Indigenous nursing students became role models to other Indigenous young people and examples of the success of the RRANN project, with their words carrying *'more weight with (the) audience than all the exhortations RRANN staff might have offered!'* (DeLapp et al. 2008, p.295).

On the JCU Thursday Island campus, a formal mentor program was implemented (based on the Queensland Health Tidda Balla mentor program for Aboriginal staff) which allowed students to regularly meet with a registered nurse. This served both a mentoring and role modelling function and also ensured students were integrated into the nursing workforce. The initial successes of the JCU Thursday Island campus that Usher et al. documented in 2005 demonstrated the utility of the satellite campus model to deliver on-site education in remote communities to develop the Aboriginal health workforce. The campus remains in operation today and now offers a post-registration degree (James Cook University, 2016).

Both the Thursday Island campus and Project RRANN included formal mentoring processes. Mentoring consistently emerged as a key strategy to aiding the development of the Aboriginal health workforce (Browne et al. 2013, EJD Consulting and Associates 2014, Foxall 2013, Moretti et al. 2014, MHCC 2014). DeLapp et al. (2008, p.296) stated that *'mentors act as guides, challengers, facilitators, insight enhancers, communicators, networkers, resources and coaches. However, mentors are not foster parents, therapists, parole officers, cool peers, or experts'*.

Furthermore, Browne et al. (2013) suggested that mentoring is a reciprocal relationship that provides opportunities for personal and professional development as well as cultural competence, particularly in mentoring relationships involving both an Indigenous and non-Indigenous participant. Despite the

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numerous benefits of mentoring, often clear descriptions of the mentoring process are not provided (Curtis et al., 2012) and as the ACIMH program evaluation demonstrated, some mentoring relationships are more effective than others (EJD Consulting and Associates, 2014). It is clear from the literature that formal mentoring processes that involve regular meetings between mentors and mentees are most useful and effective (Browne et al., 2013; EJD Consulting and Associates, 2014; Usher et al., 2005).

Improving cultural relevance and safety

The following organisational strategies have been implemented in a variety of contexts to overcome the identified barriers to Aboriginal people's ongoing participation in the health workforce:

- Incorporation of Aboriginal issues into curricula/training
- Increased flexibility in the delivery of study/training and workplace policies/practices
- Organisational commitment to equity
- Appointment of Aboriginal faculty/staff
- Increased staff understanding of Aboriginal issues and obligations via cross-cultural awareness training.

In many cases, organisational strategies to improve Aboriginal health workforce retention address more than one of these, in essence addressing aspects of cultural awareness and cultural safety. For this reason, they are not discussed under a separate heading below. Instead, key examples are used to illustrate how organisations can facilitate improved retention in education, training and workplace contexts.

A key strength of the JCU Thursday Island Campus, the Vision 20:20 and the Tjirtamai Program was the incorporation of Aboriginal content and culture into the course curriculum. The lack of Aboriginal content and cultural perspectives, and the dominance of western-centric pedagogy is frequently cited as a major barrier to Aboriginal participation in health training/study. West et al. (2010, p. 128) suggested that nursing education requires a *'critical Indigenist pedagogy, grounded in an oppositional consciousness'*. They stated that this approach to education and training would encourage different views, challenge 'colonisation, racism and oppression' and highlight the effects of these issues on Aboriginal lives and health.

West et al. (West et al., 2010) also noted that the incorporation of Aboriginal content and viewpoints into training/study would encourage more active participation from Aboriginal students and allow them to share their own experiences. Curtis and Reid (2013, p. 52) stated that the inclusion of Maori/Pacific content and methods into the CertHSc curriculum *'helped the students stay motivated to achieve success, encouraged attendance, enhanced class cohesion and re-enforced cultural pride'*.

The incorporation of Aboriginal content into course/program content is demonstrative of an organisational commitment to equity, which is an important strategy to enabling the retention of Aboriginal trainees/students. This commitment is reflected in the policies and practices of the various programmes and initiatives described in this report (Anonson, Desjarlais, Nixon, Whiteman, & Bird, 2008; Curtis & Reid, 2013; DeLapp et al., 2008; EJD Consulting and Associates, 2014; West et al., 2011). By articulating a clear message of equity and cultural sensitivity, organisations are able to mitigate or support students and staff through certain challenges commonly faced by Aboriginal people, including racism and a lack of understanding from training/study deliverers and employers. One way to increase organisational

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commitment to equity is to employ Aboriginal staff who can act as both mentors/role models and advocates for Aboriginal trainees/students and employees (Curtis & Reid, 2013).

Providing cultural awareness, competence and sensitivity training and professional development to existing staff is also an important mechanism by which to increase organisational capacity to support Aboriginal students and staff (Curtis et al., 2012; Miller, 2005). One of the most constructive recommendations provided by the ACIMH trainees was the need for more cultural awareness training in host organisations prior to employing Aboriginal people to better equip staff with the knowledge and skills to support Aboriginal trainees throughout their traineeship (EJD Consulting and Associates, 2014).

Similarly, in recognition of the need for workplaces to be inclusive and culturally safe, the Western Australian 'Working together, Training together' Aboriginal workforce development strategy includes a commitment to cross-cultural awareness training for all employees in organisations with Aboriginal staff in order to ensure staff have an understanding of Aboriginal culture (Western Australian State Government Department of Training and Workforce Development, 2010). This strategy is already in place across the state and promotes positive cultural environments in workplaces and encourages employers to 'try to accommodate Aboriginal cultural obligations' (Western Australian State Government Department of Training and Workforce Development, 2010).

In this way, increasing non-Aboriginal staff understanding of Aboriginal issues and cultural obligations is an effective strategy to counteract the racism and discrimination faced by Aboriginal trainees/students and employees. In addition, cultural awareness training provides an opportunity to increase understanding about Aboriginal peoples' need for flexibility and support regarding cultural obligations (Miller, 2005).

Facilitating recruitment

There have been a number of federal and state/territory initiatives aimed at improving organisations' recruitment of Aboriginal staff. These include the national Close the Gap initiative through to the Victorian public sector's Karreeta Yirramboi strategy, and, more recently, Koolin Balit. These Victorian frameworks have required agencies with more than 500 employees to develop an Aboriginal Employment Plan (and encouraged smaller organisations to do the same), and this has occurred among many organisations and agencies.

Karreeta Yirramboi also encouraged the resourcing of a dedicated and ongoing Aboriginal Employment Officer role within agencies (Victorian Public Sector Commission, 2010). Such roles (by various names) can facilitate not only the recruitment of Aboriginal staff, but also their retention within the organisation (*Pathways to better employment outcomes for Aboriginal people in Victorian local government*, 2012). Specialised external brokering agencies also exist to support and connect employees and job seekers (Giddy et al., 2009).

Under the special measure provision of the Equal Opportunity Act 2010, employers can identify positions for Aboriginal people as a means of improving equity in the health workforce (Victorian Government Department of Health and Human Services, 2015).

Traditional advertising techniques may not be suitable for attracting Indigenous job seekers, as their job searching methods may rely far more on personal networks as a source of information about jobs than those of non-Indigenous job seekers (Purdie & Stone, 2006). Furthermore, alternative recruitment strategies that 'give Indigenous people who would be screened out from conventional selection processes

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the opportunity to win jobs' may be important (M. Gray, Hunter, & Lohar, 2012), such as conducting job interviews within communities, including an Indigenous person on the selection committee or conducting a training course or seminar prior to selection to 'observe the candidates in action' (Grow Sydney Area Consultative Committee 2003, p.22).

Improving recruitment and retention of Aboriginal staff may, in itself, facilitate further recruitment, as 'having numbers of Aboriginal people join an organisation is more attractive to Aboriginal candidates than being the only Aboriginal person in an organisation' (Pathways to better employment outcomes for Aboriginal people in Victorian local government 2012, p.6).

While not health workforce specific, a 2012 report compiled for the Closing the Gap Clearinghouse identified successful employer-based strategies for increasing Indigenous employment, including:

- Public commitment by executive leadership to improving Indigenous employment outcomes, with adequate financial and human resourcing
- The development of sound relationships with Indigenous communities
- Corporate champions
- Qualified, skilled, informed and committed staff in training and liaison roles (M. Gray et al., 2012).

Much of this is related to organisational culture and concepts of cultural awareness, safety and competence. These are discussed further below as part of improving retention strategies.

Improving retention

Induction, mentoring and career support practices, as well as workplace and employment conditions, may be key factors in supporting the retention of Aboriginal employees (Victorian Public Sector Commission, 2010).

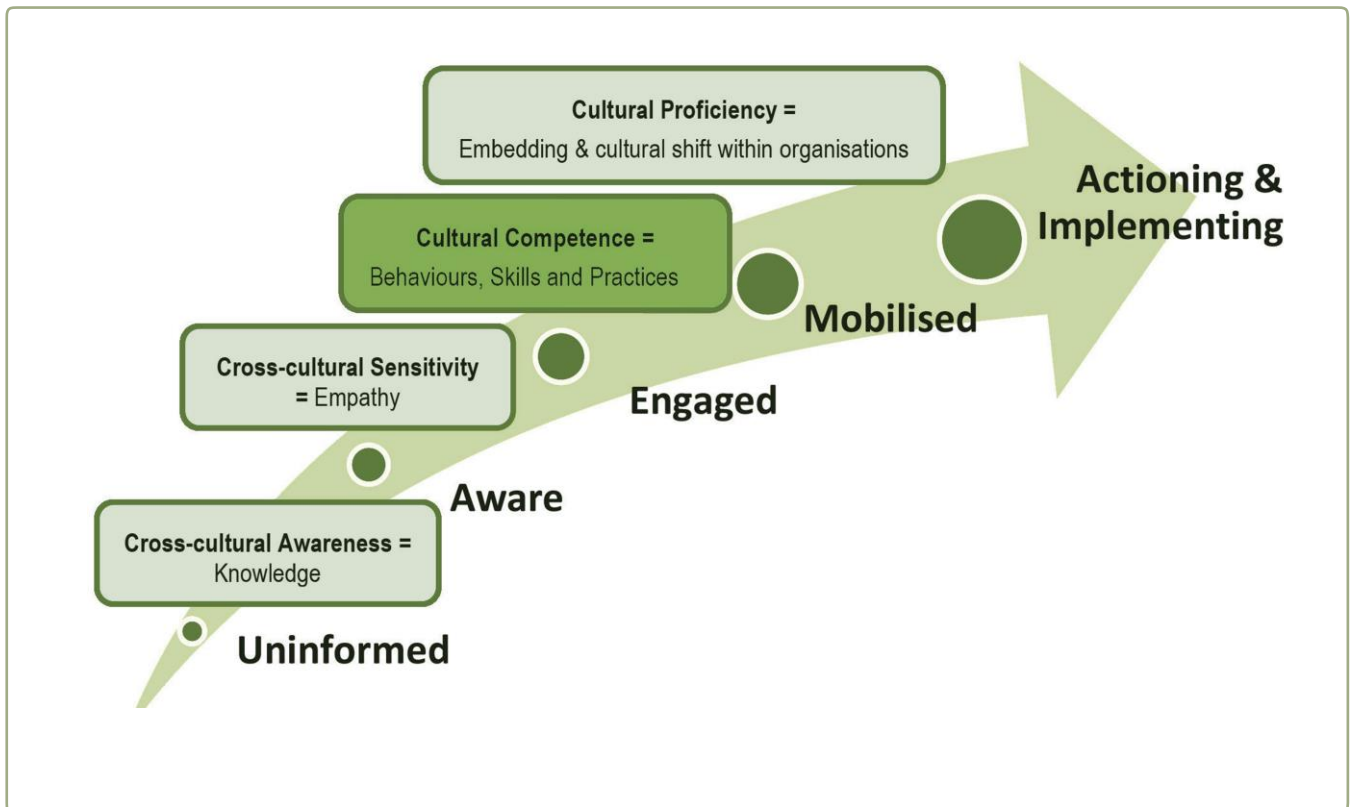
Organisational culture/awareness

Good cultural understanding/awareness within an organisation can determine both its efforts to recruit Aboriginal staff (demand) and its attractiveness to potential Aboriginal staff members (supply).

An organisation's cultural awareness and competency is considered vital to improving Aboriginal employment outcomes, as 'all staff need to genuinely understand cultural differences at each phase of the employment process: advertising, hiring, induction and ongoing retention' (Victorian Public Sector Commission 2010, p. 9).

While varying terminology is used to describe concepts of cultural awareness, sensitivity and proficiency, these can be understood as a spectrum in which cultural awareness is a starting point (see *Figure F-2*).

Figure F-2: The cultural competence continuum



Source: *Cultural competency in the delivery of health services for Indigenous people* (Bainbridge, McCalman, Clifford, & Tsey, 2015)

Tailored induction processes and flexible working arrangements (such as additional leave to allow for family or community obligations) may be considered practical manifestations of an organisation’s cultural competence (Barnett, Spoehr, & Parnis, 2008).

A 2003 report highlighted six key actions for retaining Indigenous staff:

- Have fair and realistic expectations of Indigenous staff, and discuss these with them
- Value Indigenous culture
- Exchange cultural perspectives and find common ground
- Build trust and support Indigenous staff
- Celebrate success
- Persevere to get it right (Grow Sydney Area Consultative Committee, 2003).

Mentoring and peer support

A lack of organisational capacity for necessary and appropriate staff mentoring, supervision and development can hinder Aboriginal workforce development (Mason, 2013).

Specific arrangements for mentoring, supervision, peer support and networking, particularly involving Aboriginal people (both internal and external to the employing organisation) have been described in the

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literature. For example, St Vincent's Hospital early graduate nursing project recommended a minimum cohort to facilitate peer support (Crampton & Riddington, 2012).

Professional development/career pathway development

Career development is an important component of Aboriginal workforce retention.

For traineeships, a link to employment at the conclusion of the training (e.g. an allocated position) is seen as an important component of a 'more sustainable and embedded approach to Aboriginal employment' (*Pathways to better employment outcomes for aboriginal people in victorian local government 2012*, p. 6).

Opportunities such as elective rotations (Crampton & Riddington, 2012) or acting in more senior positions can provide development pathways, and professional networking 'can help workers to deepen their connection to the health sector as a 'vocation' and facilitate long term career benefits (Bretherton, 2014). Employer-sponsored professional organisation membership and attendance at conferences may assist (Crampton & Riddington, 2012).

A broader definition of success

A 2008 report stated that 'a successful employment initiative for Aboriginal and Torres Strait Islander employment can be described as initiatives that lead to employment either directly or indirectly by overcoming barriers and creating pathways towards employment or further training.

They may also produce social, personal or community outcomes that lead to employment sometime in the future, if not immediately. For example, outcomes such as greater social harmony are not strictly employment outcomes, but increase the likelihood of employment in the future'.

Along with sustained employment, other elements of 'success' in the current context include improved health and wellbeing (including increasing participants' self-esteem), meeting local demands for skills and labour and changing community attitudes (within both Indigenous and broader communities)(Giddy et al., 2009).

Table F-2: Summary – supply and demand side barriers and organisational intervention strategy

Barriers to recruitment & retention	Example enablers and organisational strategies
Individual (supply side)	
Gaps in educational attainment (e.g. high school completion)	Interventions that encourage participation in science, maths, English at high school level
Poor academic preparedness for study/training & lack of academic confidence	Early exposure to the tertiary environment Pre-enrolment course/program

Appendix F. Review of Aboriginal health workforce development strategies outside Victoria

Barriers to recruitment & retention	Example enablers and organisational strategies
Lack of exposure to/ knowledge about career opportunities in health	Provision of effective and early career advice to Aboriginal students Marketing of education and career paths Exposure via 'taster courses' or other introductory programs Provision/marketing of role models
Public/community perceptions	Partnerships and linkages between providers, universities and the community
English language proficiency	
Personal factors (family support, personal health, financial problems)	Scholarships and stipends
Reluctance to leave local area for study/training/work	Study/training/work within community
Organisational (demand-side)	
Challenges relating to transitioning to training/study (e.g. application processes)	
Cultural insensitivity or lack of cultural relevance in training/study/work contexts Cultural alienation in place of study/training/work Racism/discriminatory practices and policies	Cultural training for employees Employing Aboriginal staff/faculty Policy development/review
Lack of access to mentors/role models	Facilitation/promotion of these relationships

Appendix G Literature scan: Barriers and enablers to recruitment, retention and career development

Appendix G. Literature scan: Barriers and enablers to recruitment, retention and career development

This appendix is set out under the following main headings:

- G.1 Recruitment and retention
- G.2 Career development.

G.1 Recruitment and retention

This section identifies key barriers to both recruitment and retention of Aboriginal and Torres Strait Islander people in health workforces (including both study/training and employment). Overall, retention of Aboriginal employees is lower than that of others, although these data may be skewed by higher proportions of casual and seasonal workers (M. Gray et al., 2012). In 2012, 88% of Aboriginal and Torres Strait Islander health workers were employed in their field – a proportion similar to overall rates for nurses and other allied health staff (Australian Government Department of Prime Minister and Cabinet, 2014b).

Demand-side barriers

In areas of limited economies, the basic level of job opportunity may provide a barrier to employment for Aboriginal and Torres Strait Islander (as well as other) people (Giddy et al., 2009). However, in Australia in recent years, strong macroeconomic conditions create job opportunities for a community as a whole, including Aboriginal people (M. Gray et al., 2012).

However, beyond this, factors such as organisational policies, including systemic racism, can limit an organisation's demand for (and capacity to support) Aboriginal and Torres Strait Islander employees. Beyond outright organisational discrimination (M. Gray et al., 2012), barriers include a lack of capacity in organisations to adequately support Aboriginal trainees and employees (Victorian State Government Department of Health and Human Services, 2015). A recent report aiming to identify drivers of career development for Aboriginal workers in the health sector suggested that 'workplace-level conditions may be having a most dramatic and destructive impact on career' (Bretherton 2014, p.6).

Supply-side barriers

Just as a lack of demand for suitably qualified and skilled candidates may be a barrier to Aboriginal health workforce development, so is inadequate supply of such individuals (Mason, 2013). It has been noted that the health sector required a high proportion of skilled workers, and regulations for professional practice (including registration and accreditation systems) dictate professional practice boundaries in most instances (Bretherton, 2014).

While Bretherton (2014) notes that supply-side factors have dominated the discussion around Aboriginal workforce development, they are important considerations, not only because they represent a key focus of the literature to date but also because they may be able to be addressed by organisational strategies to improve outcomes.

This section focuses on key barriers to the recruitment and retention of Aboriginal people into health training/study programs identified in the literature, acknowledging that completion of relevant training adds to the 'supply' available to potential employers. These included:

- Gaps in educational attainment, poor academic preparedness for study/training and limitations in 'work readiness'

Appendix G. Literature scan: Barriers and enablers to recruitment, retention and career development

- Personal factors such as financial hardship and intergenerational disadvantage and unemployment
- Challenges relating to transitioning to training/study
- Challenges faced through training/study
- Racism and lack of support.

Gaps in educational attainment and poor academic preparedness for study/training

In Australia (AHMAC 2012), New Zealand (Curtis & Reid, 2013; Curtis et al., 2012) and Canada (Anonson et al., 2008), the level of Indigenous educational attainment is considerably lower than for non-Indigenous peoples.

For example, in Australia in 2011 the retention rate¹² of full-time Aboriginal students from Year 11 to Year 12 was 68% compared with 87% for non-Aboriginal students (AHMAC 2012). Among an extensive list of barriers faced by Indigenous students is low English language proficiency, which hinders educational attainment (Anonson et al., 2008; West et al., 2011). However, the factors contributing to the educational gaps between Indigenous and other Australians are extremely complex, as the historical context of *'dispossession, segregation and assimilation have created intergenerational disadvantage and trauma that impede educational progress among most Indigenous students'* (Gray & Beresford 2008, p. 205). Importantly, analysis of data from the Longitudinal Survey of Australian Youth showed that Aboriginal children without a parent who has completed Year 12 studies are less likely to attain this level of education (or still be studying) than those who do (64.9% versus 73.3 per cent respectively) (Biddle, 2015).

Education disparities are noted in other Indigenous populations around the world. In New Zealand in 2009, 29% of Maori students received 'university entrance' at the end of their last year of school compared with 54% of non-Maori students (Curtis & Reid, 2013; Curtis et al., 2012). Similarly, in Canada, the Saskatchewan Government Relations and Aboriginal Affairs demographic report noted that educational achievement for Indigenous students was 'well below the provincial norm' (Anonson et al., 2008).

Science literacy is an important component of tertiary health courses and as such, attaining the appropriate science subjects in secondary school is often not only required for entry into health programmes (Curtis et al., 2012), but may also influence a student's ability to continue and complete tertiary health education and training. However, science literacy among Aboriginal students is also low, with 37.8% of 15-year old Aboriginal students reaching 'accepted proficiency'¹³ compared with 68.5% of non-Aboriginal students in 2009 (Expert Working Group on Indigenous Engagement with Science, 2013). Similarly, in New Zealand in 2007, only 22% of Maori secondary school students participated in a Year 13 (final year) science subject compared with 41% of non-Maori students (Curtis & Reid, 2013; Curtis et al., 2012).

The recruitment of potential Indigenous health workers may be hampered not only by gaps in educational attainment but also a lack of knowledge about prospective careers in health (Pariyo, Kiwanuka, Rutebemberwa, Okui, & Ssengooba, 2009). In the school context, careers counsellors provide career advice and this resource has the potential to inform students' aspirations for their future.

¹² Extent to which students remain at school until year 10 or year 12 (Curtis et al. 2012).

¹³ as defined by the OECD Program for International Assessment (OECD, n.d.)

Appendix G. Literature scan: Barriers and enablers to recruitment, retention and career development

In a review of careers counselling in Victorian secondary schools for Aboriginal students interested in entering medicine or other health related programmes, Chesters et al. (2009, p. 31) found that more than half the careers counsellors they surveyed demonstrated that they could not 'effectively provide complex student-centred, culturally appropriate career advice to Aboriginal students'. Importantly, more than half of the survey respondents in the Chesters et al. study indicated they would treat Aboriginal students no differently from other students and give a 'reality check' to students interested in studying medicine if they (the careers counsellor) did not believe the student was sufficiently academically capable of studying medicine. Treating Aboriginal students the same as non-Aboriginal students in this regard ignores the academic difficulties and educational inequities faced by Aboriginal students (Chesters et al., 2009).

This finding demonstrates that Victorian Aboriginal students are likely not receiving high quality careers advice at school (Chesters et al., 2009), and also suggests some possible reasons behind Aboriginal students lack of awareness of career opportunities in health, as well as their lack of confidence in their abilities to study at the tertiary level (Foxall, 2013). In their review of a program designed to increase recruitment of minority teens into Nursing in the USA, Campbell-Heider et al. (2008) cited a range of studies that have demonstrated pervasive public perceptions of nursing as 'women's work' as well as a lack of true understanding about nursing as a profession. These authors suggested that negative public perceptions as well as public misconceptions concerning the nature of nursing as a career contribute to national nursing shortages.

Personal factors

Personal factors including family history (parents' occupations and education), family support, poor health and financial problems can effect Aboriginal recruitment into health training and study programmes (Usher et al., 2005). In their report funded by the Department of Health and Ageing, the National Aboriginal and Torres Strait Islander Health Council (2008) described the barriers to health workforce participation faced by Aboriginal people, including the effect of intergenerational disadvantage particularly regarding education and employment opportunities. The authors of this report noted that Aboriginal parents and community leaders might have experienced 'negative or suboptimal education' and that correspondingly, 'Aboriginal and Torres Strait Islander people lack access to mentors and role models from the health workforce' (National Aboriginal and Torres Strait Islander Health Council, 2008, p. 5).

This problem regarding a lack of role models and mentors is repeatedly mentioned in the literature as a key barrier to the development of Aboriginal peoples' health career aspirations and recruitment into the health workforce (Browne et al., 2013; DeLapp et al., 2008; Foxall, 2013; West et al., 2011). (Foxall, 2013) also noted that the low rates of high school completion in Aboriginal communities results in a lack of understanding about the demands of training and tertiary study, which may lead to Aboriginal students being unsupported by their families.

The financial hardship faced by Aboriginal people is also well documented as a barrier to the recruitment and retention of Aboriginal students and trainees in health programmes (Curtis & Reid, 2013; Foxall, 2013; National Aboriginal and Torres Strait Islander Health Council, 2008; Usher et al., 2005; West et al., 2011). Aboriginal Australians experience higher levels of socioeconomic disadvantage than other Australians, and may take longer to complete education, so that existing financial and accommodation supports may not be adequate (National Aboriginal and Torres Strait Islander Health Council, 2008).

Appendix G. Literature scan: Barriers and enablers to recruitment, retention and career development

There may also, for a number of reasons, be differences in pay rates once in employment – for example, a recent survey AOD workers found that Aboriginal workers had a lower salary than their non-Aboriginal co-workers, even after adjustment for age, occupation, and length of service (Duraisingam, Roche, Trifonoff, & Tovell, 2010).

Challenges relating to transitioning from school to study/training

In addition to the challenges detailed above, the process involved in applying for tertiary study/training programmes is often complex and intimidating (Foxall, 2013). This may include separate processes for applying for scholarships and stipends. Without appropriate and timely advice and guidance, Aboriginal students may miss training/study and scholarship opportunities. Unfortunately, the complexity of this process is often compounded by a lack of understanding of the needs and cultural obligations of Aboriginal people by the institution or training organisation, resulting in abandonment of the application process (Foxall, 2013).

For those students who successfully apply, applicants may face isolation from their families and communities due to the training/study location, resulting in separation anxiety and homesickness which may cause students to withdraw from their program (DeLapp et al., 2008; Foxall, 2013; West et al., 2011). Additionally, these students may be entering a training/study environment that is largely non-Aboriginal and may seem foreign and unfriendly, resulting in feelings of ‘cultural alienation’ (Curtis et al., 2012). These transitional challenges are compounded by further difficulties Aboriginal people face within the tertiary training/study context, as discussed in the following sections.

Challenges faced through training/study

The challenges of cultural alienation and isolation outlined above (Curtis et al., 2012; DeLapp et al., 2008; Foxall, 2013; West et al., 2011) are compounded by difficulties with the training/study/work itself. Aboriginal students are often academically unprepared for the standards of study required in tertiary training/study contexts such as university (Usher et al., 2005; West et al., 2011). Additionally, the curricula and pedagogy of the training/study context may be subtly prejudicial and insensitive to Aboriginal issues (Foxall, 2013).

The dominance of white, Western-centric knowledge bases in health training/study programs emerged as a prominent theme in the literature and the exclusion of Aboriginal content and worldviews is viewed as a major barrier to Aboriginal completion of health training/study courses (Adams et al., 2005; Behrendt, Larkin, Griew, & Kelly, 2012; Curtis et al., 2012; Foxall, 2013; West et al., 2010). Indeed, the Institute of Koori Education suggested that Aboriginal dropout rates should be viewed as ‘rejection rates’ – rejection of the Western-centric educational system that is viewed by Aboriginal students as not ‘culturally relevant’ to them (Institute of Koorie Education, 2007).

In the workplace, there is evidence that careers in the health sector can be particularly challenging and stressful, with extended hours, low staff:patient ratios and poor management cultures contributing to stress and burnout among both Aboriginal and mainstream workforces (Bretherton, 2014).

Racism and lack of support

The issue of racism has been repeatedly cited as a major barrier to Aboriginal students completion of health training/study (Adams et al., 2005; Foxall, 2013; Kemmis, Thurling, Brennan Kemmis, Rushbrook, & Pickersgill, 2006; West et al., 2011). The majority of discussion about racism faced by Aboriginal people focused on discriminatory practices, policies and a lack of understanding and sensitivity to Indigenous issues. It is important for non-Indigenous staff, particularly those delivering training/education to Indigenous students, to understand that 'cultural obligations to family and community (are) paramount' (West et al., 2011). This issue was aptly summarised by Kemmis et al. (2006, p.46):

'The distinction between work life and home and community life may be an area in which 'Westernist' perspectives frequently emerge in policy documents and assumptions about procedures to be followed in organisations. In many jurisdictions, Indigenous people's attendance at key community cultural events (like funerals) is respected and encouraged, but issues about Indigenous attendance and performance at work raise sensitive questions about the home–community–work distinction.'

This quote articulates a major theme within the literature regarding a lack of support for Aboriginal cultural obligations and a lack of flexibility to accommodate these commitments. This lack of flexibility, understanding and support from staff is a major barrier that Aboriginal people face when attempting to complete their training/study (Adams et al., 2005; Curtis et al., 2012; Foxall, 2013; West et al., 2010). Without this support, feelings of isolation and cultural alienation may be exacerbated. Furthermore, gaps in academic preparedness for training/study will not be addressed in situations where the Aboriginal student does not feel safe or supported by the staff delivering their training/study.

G.2 Career development

Career establishment and development are important components of Aboriginal workforce retention.

Assessment of the extent to which career establishment has occurred in the Aboriginal workforce context first requires defining what is meant by 'establishing a career'. From a theoretical viewpoint, the term 'career' is multifaceted. It not only contains objective and subjective perspectives but is also rich in external and internal meaning, all of which are intrinsically related.

From an **objective** perspective, a career refers to the sequence of positions occupied by the person in the course of their lifetime. From a **subjective** perspective, a career relates to the person's sense of where he/she is going in their work life (Sims & Sims, 2007, p. 379). These perspectives are further overlaid by layers of meaning whereby, in the case of **external viewpoint**, the term 'career' describes the organisational and/or socially recognised progression of steps through a given occupation. In contrast, **internal career** is a psychological or personal construct underpinned by factors such as self-development and motivation as the individual progresses through external careers (Arthur, Hall, & Lawrence, 1989).

Intrinsically linked with career is the idea of a **successful career**. Traditionally, career success was defined in terms of occupational advancement. However, more recently, career theorists have argued that 'the ultimate goal of career success is psychological success, the feeling of pride and personal achievement that comes from achieving your most important goals.' (Sims & Sims, 2007, p. 381). This not only involves 'periodic cycles of skill apprenticeship, mastery and reskilling' but also:

Appendix G. Literature scan: Barriers and enablers to recruitment, retention and career development

- Considerations of lateral as well as upward movement
- Recognition of the importance of cross-functional experience in developing multi-skilling and continued employability (Sims & Sims, 2007, p. 381).

Appendix H Cited references

Appendix H. Cited references

- Aboriginal Workforce Development Centre. (n.d.). *What works in Aboriginal pre-employment programs*. Perth: Government of Western Australia Department of Training and Workforce Development.
- ACT Government Health. (n.d.). Health workforce and scholarships. Retrieved from <http://health.act.gov.au/our-services/aboriginal-torres-strait-islander-health/health-workforce-and-scholarships>
- ACT Health. (2008). *Aboriginal and Torres Strait Islander Health Workforce Action Plan 2013-2018*. ACT Health.
- Adams, M., Aylward, P., Heyne, N., Hull, C., Misan, G., Taylor, J., & Walker-Jeffreys, M. (2005). Integrated support for Aboriginal tertiary students in health-related courses: the Pika Wiya learning centre. *Australian Health Review*, 29(4), 482–488.
- Anonson, J. M., Desjarlais, J., Nixon, J., Whiteman, L., & Bird, A. (2008). Strategies to support recruitment and retention of First Nations youth in baccalaureate nursing programs in Saskatchewan, Canada. *Journal of Transcultural Nursing*, 19(3), 274–283. <http://doi.org/10.1177/1043659608317095>
- Arthur, M. B., Hall, D. T., & Lawrence, B. S. (1989). *Handbook of career theory*. (M. B. Arthur, D. T. Hall, & B. S. Lawrence, Eds.). Cambridge: [online, 2012] Cambridge University Press. <http://doi.org/10.1017/CBO9780511625459>
- Australian Bureau of Statistics. (2006). Census of population and housing – employment, income and unpaid work. Retrieved November 2, 2015, from <http://www.abs.gov.au/websitedbs/censushome.nsf/home/tablebuilder?opendocument&navpos=240>
- Australian Bureau of Statistics. (2011a). 2011 Census Counts: Aboriginal and Torres Strait Islander peoples. Retrieved November 2, 2015, from <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2075.0main+features32011>
- Australian Bureau of Statistics. (2011b). 2076.0 - Census of Population and Housing: Characteristics of Aboriginal and Torres Strait Islander Australians,. Retrieved November 2, 2015, from <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2076.0main+features802011>
- Australian Government Department of Employment. (2016). Long term unemployed and Indigenous wage subsidy. Retrieved May 4, 2016, from <https://www.employment.gov.au/long-term-unemployed-and-indigenous-wage-subsidy>
- Australian Government Department of Health and Ageing. (n.d.). Health Jobs | Health Careers | Aboriginal Health Jobs | NSW, VIC, QLD, WA, ACT, SA, NT, Australia | Health Heroes - Department of Health and Ageing. Retrieved June 10, 2016, from <http://www.healthheroes.health.gov.au/internet/heroes/publishing.nsf/Content/Home>
- Australian Government Department of Prime Minister and Cabinet. (n.d.). Indigenous Advancement Strategy: Tailored assistance employment grants. Retrieved May 4, 2016, from https://www.dpmc.gov.au/sites/default/files/files/ia/Tailored_Assistance_Employment_Fact_Sheet.pdf
- Australian Government Department of Prime Minister and Cabinet. (2014a). Aboriginal and Torres Strait Islander people in the health workforce. Retrieved May 3, 2016, from <https://www.dpmc.gov.au/sites/default/files/publications/indigenous/Health-Performance-Framework-2014/tier-3-health-system-performance/312-aboriginal-and-torres-strait-islander-people->

Appendix H. Cited references

health-workforce.html

- Australian Government Department of Prime Minister and Cabinet. (2014b). Recruitment and retention of staff. Retrieved May 11, 2016, from <https://www.dpmc.gov.au/sites/default/files/publications/indigenous/Health-Performance-Framework-2014/tier-3-health-system-performance/322-recruitment-and-retention-staff.html>
- Australian Health Ministers' Advisory Council. (2012). *Aboriginal and Torres Strait Islander health performance framework*. Canberra: Australian Government Department of Health and Ageing.
- Australian Indigenous Doctors' Association. (2010). *Improving the Transition into Health Careers for Aboriginal and Torres Strait Islander school students*. A policy paper by AIDA for the Department of Education Employment and Workplace Relations (DEEWR).
- Bainbridge, R., Mccalman, J., Clifford, A., & Tsey, K. (2015). *Cultural competency in the delivery of health services for Indigenous people*. Canberra: Issues paper no.13 produced for the Closing the Gap Clearinghouse. Retrieved from http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Our_publications/2015/ctgc-ip13.pdf
- Barnett, K., Spoehr, J., & Parnis, E. (2008). *Equity Works: Achieving the Target of 2% Aboriginal Employment in the South Australian Public Sector: Summary report*. Adelaide: The Australian Institute for Social Research, Dunstan Paper No. 1/2008.
- Behrendt, L., Larkin, S., Griew, R., & Kelly, P. (2012). *Review of higher education access and outcomes for Aboriginal and Torres Strait Islander people: Final report*. Canberra: Commonwealth of Australia.
- Best, O., & Stuart, L. (2014). An Aboriginal nurse-led working model for success in graduating Indigenous Australian nurses. *Contemporary Nurse*, 48(1), 59–66. <http://doi.org/10.5172/conu.2014.48.1.59>.
- Biddle, N. (2015). *Entrenched disadvantage in Indigenous communities*. Melbourne: Chapter in: Addressing entrenched disadvantage in Australia, Committee for Economic Development of Australia (CEDA).
- Bretherton, T. (2014). *Shifting Gears in Career: Identifying drivers of career development for Aboriginal and Torres Strait Islander workers in the health sector*. Melbourne: The Lowitja Institute.
- Browne, J., Thorpe, S., Tunny, N., Adams, K., & Palermo, C. (2013). A qualitative evaluation of a mentoring program for Aboriginal health workers and allied health professionals. *Australian and New Zealand Journal of Public Health*, 37(5), 457–62. <http://doi.org/10.1111/1753-6405.12118>
- Campbell-Heider, N., Sackett, K., & Whistler, M. P. (2008). Connecting With Guidance Counselors to Enhance Recruitment Into Nursing of Minority Teens. *Journal of Professional Nursing*, 24(6), 378–384. <http://doi.org/10.1016/j.profnurs.2008.10.009>
- Chesters, J., Drysdale, M., Ellender, I., Faulkner, S., Turnbull, L., Kelly, H., ... Chambers, H. (2009). Footprints forwards blocked by a failure discourse: Issues in providing advice about medicine and other health science careers to Indigenous secondary school students. *Australian Journal of Career Development*, 18(1), 26–35. <http://doi.org/10.1177/103841620901800105>
- Community attitudes to Indigenous education, training and employment*. (2011). Generation One and Auspoll.
- Crampton, R., & Riddington, D. (2012). *Aboriginal and Torres Strait Islander Early Graduate Nurse Project*.

Appendix H. Cited references

Melbourne: St Vincent's.

- Curtis, E., & Reid, P. (2013). Indigenous Health Workforce Development: challenges and successes of the Vision 20:20 programme. *ANZ Journal of Surgery*, 83(1–2), 49–54. <http://doi.org/10.1111/ans.12030>
- Curtis, E., Wikaire, E., Stokes, K., & Reid, P. (2012). Addressing Indigenous health workforce inequities: A literature review exploring “best” practice for recruitment into tertiary health programmes. *International Journal for Equity in Health*, 11(1), 13. <http://doi.org/10.1186/1475-9276-11-13>
- DeLapp, T., Hautman, M. a, & Anderson, M. S. (2008). Recruitment and retention of Alaska natives into nursing (RRANN). *Journal of Nursing Education*, 47(7), 293–297. <http://doi.org/Article>
- Department of Education, E. and W. R. (2013). *Indigenous Employment: The Australian Government's Contribution to the Australian Employment Covenant*. Canberra: Commonwealth of Australia.
- Department of Health and Human Services. (2015). *Koolin Balit SSW Training Grants 2015-16 Guidelines_EOI.pdf*. Department of Health and Human Services.
- Department of Human Services & Department of Health. (2013). *Aboriginal recruitment and retention strategy 2010-2013 year 3*. Melbourne: Victorian Government Department of Human Services. Retrieved from file:///N:/AHA Projects/Projects 2015/DHHS Aboriginal Workforce/Research and literature/Background refs/Aboriginal recruitment and retention strategy 2010-2013 year 3.pdf
- Duraisingam, V., Roche, A., Trifonoff, A., & Tovell, A. (2010). *Indigenous AOD Workers' Wellbeing, Stress and Burnout: Findings from an online survey*. Adelaide: National Centre for Education and Training on Addiction (NCETA), Flinders University.
- EJD Consulting and Associates. (2014). *Aboriginal careers in mental health: Final evaluation report*. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/15003161>
- Expert Working Group on Indigenous Engagement with Science. (2013). *Indigenous engagement with science: towards deeper understandings*. Canberra: Inspiring Australia.
- Foxall, D. (2013). Barriers in education of Indigenous nursing students: A literature review. *Nursing Praxis in New Zealand*, 29(3), 31–36.
- Giddy, K., Lopez, J., & Redman, A. (2009). *Brokering successful Aboriginal and Torres Strait Islander employment outcomes: common themes in good-practice models*. Adelaide: National Vocational Education and Training Research Program, Australian Government.
- Government of WA Department of Training and Workforce Development. (n.d.). Aboriginal Workforce Development Centre. Retrieved from <http://www.dtwd.wa.gov.au/AWDC>
- Gray, J., & Beresford, Q. (2008). A “formidable challenge”: Australia's quest for equity in Indigenous education in Indigenous education. *Australian Journal of Education*, 52(2), 197–223.
- Gray, M., Hunter, B., & Lohoar, S. (2012). *Increasing Indigenous employment rates*. Australian Institute of Health and Welfare and Australian Institute of Family Studies, Issues paper no. 33 produced for the Closing the Gap Clearinghouse. <http://doi.org/978-1-74249-438-8>
- Grow Sydney Area Consultative Committee. (2003). *Getting it Right Employing Indigenous Australians: Guide for Employers*. Sydney: NSW State Office of the Department of Education, Employment and Workplace Relations (DEEWR).

Appendix H. Cited references

- Hassan, E. (n.d.). Recall Bias can be a Threat to Retrospective and Prospective Research Designs. Retrieved May 18, 2016, from <http://ispub.com/IJE/3/2/13060>
- Human Services Advisory Council inc. (n.d.). NT Aboriginal health and community services workforce planing and development strategy 2012. Retrieved from <http://www.hstac.com.au/WorkforceStrategy/overview.html>
- Institute of Koorie Education. (2007). Education and social justice: why Indigenous education programs cannot succeed without a critically reflective teaching practice. *Professional Voice*, 4(3), 19–22.
- James Cook University. (2016). Thursday Island - James Cook University Australia. Retrieved January 15, 2016, from <https://www.jcu.edu.au/courses-and-study/cities-campuses-and-study-centres/thursday-island>
- Kemmis, S., Thurling, M., Brennan Kemmis, R., Rushbrook, P., & Pickersgill, R. (2006). *Indigenous staffing in vocational education and training: Policies, strategies and performance*. Adelaide: National Centre for Vocational Education Research (NCVER).
- Mason, J. (2013). *Review of Australian government health workforce programs*. Commonwealth of Australia.
- Mental health coordinating council. (2014). *Aboriginal careers in mental health initiative - Aboriginal workforce development strategy*. Sydney: Australian Government Department of Education, Employment and Workplace Relations (DEEWR) and NSW State Training Services (STS).
- Miles, M. B., Huberman, A. M., & Saldana, J. (2013). *Qualitative Data Analysis: A Methods Sourcebook* (Third). Thousand Oaks, California: Sage. Retrieved from http://www.amazon.com/Qualitative-Data-Analysis-Sourcebook-Paperback/dp/B00ZVP3VKU/ref=sr_1_2?s=books&ie=UTF8&qid=1445487701&sr=1-2&keywords=miles+huberman+saldana
- Miller, C. (2005). *Aspects of training that meet Indigenous Australian's aspirations: A systematic review of research*. Adelaide: National Centre for Vocational Education Research (NCVER).
- Moretti, C., Spoehr, J., & Barbaro, B. (2014). *Regional Aboriginal workforce development: A strategic framework for South Australian local government*. Adelaide: main report, Australian Workplace Innovation and Social Research Centre, The University of Adelaide.
- National Aboriginal and Torres Strait Islander Health Council. (2008). *A blueprint for action: Pathways into the health workforce for Aboriginal and Torres Strait Islander people*. Canberra: Commonwealth of Australia.
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011-2015*. (2011). Canberra: Prepared for The Australian Health Ministers' Advisory Council by the Aboriginal and Torres Strait Islander Health Workforce Working Group.
- Noetic Solutions. (2012). *Aboriginal Health Workforce Survey*. Sydney: report for NSW Ministry of Health, Noetic Solutions.
- Northern Territory Aboriginal Health and Community Services Workforce Planning and Development Strategy 2012. (2012). *Case study: school-to-work transition*.
- NSW Council of Social Services. (2007). *Models of workforce development*. Sydney: NCOSS.

Appendix H. Cited references

- NSW Government Health. (n.d.). Publications and policy directives. Retrieved from <http://www.health.nsw.gov.au/workforce/aboriginal/Pages/publications.aspx>
- NSW Government Ministry of Health. (2011). *Aboriginal Workforce Strategic Framework 2011-2015: Good health - great jobs*.
- NSW Ministry of Health. (n.d.). Stepping Up. Retrieved from www.steppingup.health.nsw.gov.au
- OECD. (n.d.). Programme for international student assessment. Retrieved from <https://www.oecd.org/pisa/>
- OECD. (2002). *Glossary of Key Terms in Evaluation and Results Based Management*. Network on Development Evaluation .
- Pariyo, G. W., Kiwanuka, S. N., Rutebemberwa, E., Okui, O., & Ssengooba, F. (2009). Effects of changes in the pre-licensure education of health workers on health-worker supply. *The Cochrane Database of Systematic Reviews*, (2). <http://doi.org/10.1002/14651858.CD007018.pub2>
- Pathways to better employment outcomes for Aboriginal people in Victorian local government*. (2012). Melbourne: Municipal Association of Victoria. Retrieved from [http://www.mav.asn.au/policy-services/social-community/indigenous/aboriginal-employment/Documents/Pathways to better employment outcomes for Aboriginal people in local government.docx](http://www.mav.asn.au/policy-services/social-community/indigenous/aboriginal-employment/Documents/Pathways%20to%20better%20employment%20outcomes%20for%20Aboriginal%20people%20in%20local%20government.docx)
- Pawson, R., & Tilley, N. (2011). *Realistic Evaluation*. London: Sage Publications. Retrieved from http://www.amazon.com/Realistic-Evaluation-Ray-Pawson/dp/0761950095/ref=sr_1_1?s=books&ie=UTF8&qid=1445473814&sr=1-1&keywords=realistic+evaluation
- Purdie, N., & Stone, A. (2006). Enhancing employment opportunities for Indigenous Victorians: A Review of the Literature.
- Queensland Aboriginal and Islander Health Council. (n.d.). Workforce Development. Retrieved May 9, 2016, from <http://www.qaihc.com.au/business-units/sector-development/workforce-development/>
- Queensland Health. (2010a). *Making Tracks toward closing the gap in health outcomes for Indigenous Queenslanders by 2033: policy and accountability framework*. Brisbane: The State of Queensland (Queensland Health).
- Queensland Health. (2010b). *Queensland Health Aboriginal and Torres Strait Islander Cultural Competency Framework 2010-2033*. Brisbane: The State of Queensland (Queensland Health). <http://doi.org/10.1017/CBO9781107415324.004>
- Roche, A. (2001). What is this thing called workforce development. Retrieved from <http://nceta.flinders.edu.au/files/7712/5548/1891/EN91.pdf>
- SA Health. (2009). *SA Health Aboriginal Workforce Reform Strategy 2009-2013*. Adelaide: Government of South Australia (SA Health).
- Sims, S. J., & Sims, R. R. (2007). Human resource management and career management and development. In R. R. Sims (Ed.), *Human Resource Management: Contemporary Issues, Challenges, and Opportunities* (pp. 377–420). USA: IAP. Retrieved from <https://books.google.com/books?id=2pNfy7sKrRIC&pgis=1>
- Social Ventures Australia. (2016). *Fundamental principles for youth employment*. Social Ventures Australia.

Appendix H. Cited references

- Stewart, J. (2014). Thousands of nursing graduates unable to find work in Australian hospitals: union.
- Sutton, K., Maybery, D., & Moore, T. (2012). Bringing them home: A Gippsland mental health workforce recruitment strategy. *Australian Health Review*, 36(1), 79–82. <http://doi.org/10.1071/AH11003>
- Tasmanian Government Department of Health and Human Services. (n.d.). Ida West Aboriginal health scholarship. Retrieved from <http://www.dhhs.tas.gov.au/career/home/scholarships>
- The State Services Authority Victoria. (2011). *Karreeta Yirramboi: An Employer Toolkit to grow Aboriginal employment in your organisation*. Melbourne: The State Services Authority. Retrieved from http://vpvc.vic.gov.au/wp-content/uploads/2015/02/5081_931_Karreeta_Yirramboi_Kit.pdf
- Usher, K., Lindsay, D., & Mackay, W. (2005). An innovative nurse education program in the Torres Strait Islands. *Nurse Education Today*, 25, 437–441.
- Victorian Government Department of Health. (2014). *Koolin balit: Aboriginal health workforce plan 2014-17*. Melbourne: Victorian Government Department of Health.
- Victorian Government Department of Health and Human Services. (2015). *Reserving employment positions for Aboriginal people*. Melbourne: Victorian Government.
- Victorian Government Department of Health and Human Services. (2016). *Nurse and midwife graduate handbook 2016*. Melbourne: State of Victoria.
- Victorian Public Sector Commission. (2010). *Karreeta yirramboi*.
- Victorian State Government Department of Health and Human Services. (2015). *Implementing an Aboriginal cadetship program: A guide for public health services*. Melbourne: Victorian State Government Department of Health and Human Services.
- West, R., Usher, K., & Foster, K. (2010). Increased numbers of Australian Indigenous nurses would make a significant contribution to “closing the gap” in Indigenous health: What is getting in the way? *Contemporary Nurse*, 36(1–2), 121–130. <http://doi.org/10.5172/conu.2010.36.1-2.121>
- West, R., West, L., West, K., & Usher, K. (2011). Tjirtamai-’to care for’: A nursing education model designed to increase the number of Aboriginal nurses in a rural and remote Queensland community. *Contemporary Nurse*, 37(1), 39–48. <http://doi.org/10.5172/conu.2011.37.1.039>
- Western Australian State Government Department of Training and Workforce Development. (2010). *Working together, training together: Sustainable employment outcomes for Aboriginal people through training*. Western Australian State Government Department of Training and Workforce Development. <http://doi.org/http://dx.doi.org/10.1016/j.jen.2013.07.002>