CATSINaM

# CATSINaM Mentoring Program Review Report

## May 2014

CONGRESS OF ABORIGINAL AND TORRES STRAIT ISLANDER NURSES AND MIDWIVES
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*Unity and Strength through Caring*

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# Executive Summary

Strengthening recruitment and retention of Aboriginal and Torres Strait Islander nurses and midwives through mentoring has been a long-term priority of CATSINaM. However, it has been challenging to provide such mentoring as a small national organisation with limited capacity. The 2013-2014 consultation process with CATSINaM members highlighted that mentoring remains a priority – both as a program that CATSINaM provides and for professional development. On this basis, CATSINaM instituted a review of the existing mentoring program so a revised program could be designed and options for resourcing it identified.

This report outlines the review process, issues to address and proposed solutions for a revised mentoring program. The external context in which CATSINaM operates, conclusions and recommendations is summarised below. This will form the basis for:

- a costed funding proposal for a revised CATSINaM Mentoring Program
- an engagement strategy so that educational institutions and employers become partners, co-funders and mutual beneficiaries in the provision of mentoring support.

## CHARACTERISTICS OF THE BROADER ENVIRONMENT

At this juncture, there are very few formal and ongoing mentoring programs focused on directly supporting Aboriginal and Torres Strait Islander health professionals, whether as students, graduates or experienced professionals. However, there is high interest in mentoring as a priority strategy for professional support and retention amongst Aboriginal and Torres Strait Islander health professionals, and in the nursing and midwifery literature. There is almost no published material on ***formal*** mentoring programs for Aboriginal and Torres Strait Islander health professionals, let alone Aboriginal and Torres Strait Islander nurses and midwives.

The most recent Australian health workforce data clearly identifies that Aboriginal and Torres Strait Islander nurses and midwives form a very small proportion of the overall nursing and midwifery workforce: the national figure is 0.8% although this varies across jurisdictions. Data on student retention and completion rates is scarce. Older national data for 2004-2008 indicates that completion rates for Indigenous pre-registration nursing students is 28% lower on average than for non-Indigenous students. This underscores the critical need to implement well-grounded and appropriate resourced strategies that support Aboriginal and Torres Strait Islander nursing and midwifery students and graduates, and ensure workforce representation is increased and sustained over time.

There are limited options for funding at a national level to resource a revised CATSINaM Mentoring Program. However, there are opportunities at the state/territory government level as they have a responsibility to meet Aboriginal health workforce targets (2.6% as defined by the National Aboriginal and Torres Strait Islander Health Workforce Strategic

Framework 2011-2015, as well as with universities that need to achieve student completion KPIs in order to ensure their funding base. Further, universities must meet accreditation standards for their nursing and midwifery courses, and support for Aboriginal and Torres Strait Islander students are specifically identified in these standards.

At an individual level for Aboriginal and Torres Strait Islander nurses and midwives, participation in a mentoring program can contribute to meeting the continuing professional development requirements for maintaining their registration.

## SUMMARY OF THE REVIEW CONCLUSIONS

The review conclusions were developed on the basis of critical questions that define the focus and shape of a revised mentoring program, and have led to eight recommendations as outlined below.

In brief, the review determined there is a clear need for mentoring and that Aboriginal and Torres Strait Islander student and graduate nurses and midwives are the highest priority groups at this point in time. CATSINaM cannot take sole responsibility for providing mentoring, as educational institutions and employers have a high stake in supporting Aboriginal and Torres Strait Islander nursing and midwifery students and graduate to be successful in their studies and work. Therefore, they need to become partners and co-funders in the revised CATSINaM Mentoring Program. This may result in running programs in different localities that are customised to meet local needs, rather than a central or national program, so a flexible approach is needed for how funding arrangements may occur, although these arrangements must be formalised through partnership agreements.

Having reviewed the work to date on mentoring programs for Aboriginal and Torres Strait Islander health professionals, it was determined that a structured mentoring program is required, which will form the 'core elements' of the CATSINaM Mentoring Program, even if there are different sub-programs run based on a range of co-funding and partnering arrangements. Further, it should be formally evaluated as not only will CATSINaM gain the benefit of strengthening program process and outcomes, but publishing the outcomes will fill a void in the literature on how best to operate such a program for Aboriginal and Torres Strait Islander health professionals, particularly one that is more than a short-term pilot. Part of the formality of the program includes setting criteria for participation, as it is likely that demand may outstrip capacity as the program becomes better known.

Finally, there is little interest or wisdom in running a pilot or demonstration program. While the CATSINaM Mentoring Program may start small, it needs to be a sustainable program that provides a long-term commitment to providing unique professional support for and enabling retention of Aboriginal and Torres Strait Islander Australians in the nursing and midwifery profession. Part of the uniqueness of the CATSINaM Mentoring Program is that it will assist Aboriginal and Torres Strait Islander nursing and midwifery students and graduates to strengthen personal strategies for their cultural safety and managing racism in learning and workplace environments.

## RECOMMENDATIONS

1. **Priority participants:** Offer the program to student nurses and midwives, and graduates or early career nurses and midwives (in their first 5 years of practice) as the priority participants.
2. **Program partners and co-funders:** State and territory health departments and educational institutions should be formally approached by CATSINaM regarding their willingness to partner with CATSINaM in co-funding a mentoring program that supports Aboriginal and Torres Strait Islander graduate and/or student nurses and midwives.
3. **Core elements of the mentoring program:** CATSINaM should develop a structured mentoring program that requires potential Mentors to undertake training, applications be submitted for participation based on meeting agreed criteria (for both Mentors and Mentees), a matching process to occur, core mentoring resources/documents to be developed and used, and formal quality assurance and monitoring activities to be undertaken.
4. **Formal evaluation:** The program proposal should include funding for a formal evaluation to be conducted after 12-18 months from program launch, as well as after three years of operation.
5. **Criteria for participation:** Clear criteria should be established for Mentors that focus on, personal qualities, experience and availability, while criteria for Mentees should focus on access to alternative options, need for personal development and professional support, and level of risk of leaving study or the workforce.
6. **Mentor peer support:** Mentor peer support should be a formal part of the program, with Mentors required to attend a minimum of one mentor networking event per year.
7. **Flexibility in the funding proposal:** The core program elements should be identified in the funding proposal and accompanied by different costed options to reflect: a student and a graduate program stream; examples of a local, jurisdictional and national program; and the capacity for resource efficiencies through collaborative work.
8. **Timeframe:** The funding proposal should be described as 'Phase 1' and have an initial three year timeframe.

# Background

## Reason for the review

Since its inception, CATSINaM has been conscious of the need to support Aboriginal and Torres Strait Islander nursing and midwifery students to support successful completion of their studies and retention in the workforce. Mentoring has been one of the recommended approaches. CATSINaM sought to provide mentoring but has faced limitations in implementing a program in terms of both funding and volunteers from its Members.

As CATSINaM enters a new era with the advent of its first CEO, a five-year strategic plan for 2013-2018, a new image and name, and a multiple strategy Member consultation process, it was considered timely to formally review the learnings gained from CATSINaM's endeavours to provide a mentoring program to date. As a result, a revised and expanded program could be developed, and a funding strategy and submission with the intent that funding is secured to establish it in the 2014-2015 financial year.

A five member Steering Committee was established in February 2014 to oversee the review, with a timeframe of March-June 2014. The terms of reference are provided in Appendix A. The membership of the Steering Committee is:

- Faye Clarke, Board Member and mentor
- Benjamin Gorrie, Victorian Member and mentor
- Wade Johnstone, NSW Member and mentee
- Karel Williams, ACT Member and mentee
- Karen Atkinson, SA Member and mentor

## History of the CATSIN Mentoring Program

The previous CATSIN Mentoring Program has been operating sporadically for several years with a focus on student nurses and midwives as the priority group. The main document describing the program is the 'CATSIN Mentoring Workbook' from 2011. No formal training was provided for CATSINaM Members who became Mentors. There was a staff member (non-Aboriginal) who took on the role of Mentoring Program Coordinator who responded to queries about the program, took expressions of interest from potential Mentors and Mentees, supported the process of linking Mentors and Mentees, and was the contact point for any concerns or issues with the program from participants. The role also included providing some of the mentoring support.

The old CATSIN website, which is about to be superseded, had a section on the website where the CATSIN Mentoring Program was described. The aims were to:

- help the individual who is studying to be a nurse or midwife
- address the shortage of Aboriginal and Torres Strait Islander peoples in nursing and midwifery by supporting students
- assist students to prepare for a long and rewarding nursing or midwifery career.

Mentoring within the CATSIN mentoring program was described as:

> *An experienced nurse or midwife and student nurse or midwife working in partnership to build a healthy, trusting, sharing, and growing relationship. The mentor and student developing a relationship which provides support, guidance, role modeling, friendship, and assistance. The mentor and student being willing to learn, and develop a relationship leading to professional growth.*

The 'CATSIN Mentoring Workbook' and website emphasized that: "Mentoring is not just about sharing knowledge, ideas and skills but about growing into the complex role of the nurse or midwife."

Goals and expectations of mentoring were also described in both locations. It was stated that "the student and mentor need to work together to discuss and agree on goals and aims. Goals and aims usually change along the way…[and] will be different depending on the situation". Participants were encouraged to "take some time to periodically review your joint goals and aims. This can be a formal or informal process." They were also advised to make plans on how and when contact would occur.

CATSIN's role in the program was described as to:

> *"… learn about the mentors and the students, so that the expertise of the mentor can be matched to the needs of the student, link the student to the right mentor, be a resource for information and support to the mentor, and be a contact point for support and assistance with any unusual or unfair problems. Infrequently, a relationship does not work… [so] CATSIN can discuss finding a different mentor."*

## REFLECTION ON THE EXISTING PROGRAM

At the first Steering Committee meeting, Committee Members reflected on their experience of the CATSIN Mentoring Program, which they reported had existed for some time although not in a consistent or overly active manner. In summary, it was described as an informal and unstructured program where mentors volunteered their time but were not trained in supporting students. There was not sufficient clarity about the role and expectations of Mentors. There was not clear understanding from students that it existed and what they could gain or expect from it as it was not well promoted.

# Mentoring needs of CATSINaM members

## Consultation on mentoring needs in CATSINaM

CATSINaM has built a strong picture of members' mentoring needs and experiences through the three components of 2013-2014 member consultation strategy:

- the 2013 member online survey
- the Yarning Circles at the 2013 Annual Conference
- the 2013-2014 member recruitment and promotion forums (which will be completed by early April 2014).

### 2013 CATSINaM Member online survey outcomes

The 2013 Member online survey included several questions focused on knowledge and opinions of the existing Mentoring Program. Participants included 57 CATSINaM Members (~28% of the total membership at that time) and 11 non-Members; 67 people in total. The survey report concluded that:

> *There was a somewhat low level of awareness of this program, with one in three participants indicating that they had not been aware of the program. 64% of members have not been involved in the mentoring program in any way. Of those that had taken part in the program, half were unsatisfied with it. (p.6)*

Awareness of the program was slightly lower in regional areas compared to metropolitan areas, and much lower for new compared to older Members. Of those who were aware of it and had interacted with it in some form, satisfaction levels were quite low, with 50% being 'unsatisfied'. However, the vast majority (86%) of the 21 Members and non-Members who learned about the program through the survey indicated they would be interested in taking part in it in the future.

Over half of survey respondents wanted CATSINaM to offer more mentoring services in the future. The desire for greater access to mentoring is directly linked to the respondents indicating that limited access to mentoring was one of the barriers to undertaking and completing tertiary studies in nursing and midwifery for Aboriginal and Torres Strait Islander Australians, as well as continuing in the profession. If this occurred, then the following improvements were proposed: better promotion in liaison with universities and government departments, a more structured process, formal training for mentors, monthly monitoring of mentee satisfaction, and an overall expansion of the program that enables access in both metropolitan and regional locations across Australia.

In responding to questions around professional development training, 82% of participants indicated that CATSINaM should work towards providing this. Mentoring was one of the top three topics identified as priorities, identified by 82%, along with cultural safety (82%)

and leadership (90%). The interest in professional development on mentoring was as high for survey respondents from metropolitan as regional areas, and for those who were over or under 40 years of age.

## 2013 Conference Yarning Circles outcomes

The outcomes of the Yarning Circles at the 2013 Conference are consistent with the survey results. In the Yarning Circles, Members discussed their expectations and hopes for what CATSINaM provides Members in terms of member support, professional development and member benefits, and also put forward priorities for policy development within CATSINaM and research topics in which CATSINaM may be involved.

In terms of member support, mentoring support for student nurses and midwives was frequently identified, but also for qualified early career nurses and midwives to support them in making a solid start to their career, and qualified experienced nurses and midwives as they more into new areas, e.g. research and publications. In fact, participants believed that it was essential that CATSINaM review, strengthen and extend the mentoring program to reach more Members at different levels of experience/career stage, and called for a clear framework for the program and training for mentors.

In proposals for professional development, once again mentoring was identified as a high priority professional development topic. When identifying priority issues on which CATSINaM should formalise and promote policy positions, mentoring for student and graduate nurses and midwives was nominated as a critical aspect of any policy on workforce recruitment, retention and workforce development.

## Member forums outcomes

CATSINaM is currently finalising a series of face-to-face forums and teleconferences as part of its wider Member consultation and recruitment strategy (to be completed by early May). Although a formal report is not yet available, discussions to date have reinforced the survey and Yarning Circle outcomes, as the need for and value of mentoring has been raised at all forums and teleconferences. A mentoring program is consistently identified as an essential aspect of member support that CATSINaM should provide, and training in mentoring as an essential topic to include in professional development offerings.

In summary, Members want and need a mentoring program. They expect CATSINaM to be active in this area and to take steps to formalise the program and improve how it has been provided in the past.

# Mentoring needs at different career stages

The Steering Committee examined the mentoring needs of members at the following different career stages in detail: students, graduates and early career nurses and midwives

(1 – 5 years), mid-career nurses and midwives (6 – 20 years), and later career nurses and midwives (20+ years). The outcomes are shown in the set of tables below for each group.

The original intention was to analyse the ***successes*** and ***challenges*** of the existing mentoring program in addressing these needs, and then the current ***enablers*** and ***barriers*** for a future program. However, this occurred for the first two groups of Members only. Through the process of discussing needs it was decided they were the high priority groups for a revised mentoring program as they are the most vulnerable to higher attrition rates.

## Table 1: Student nurses and midwives

| Needs | |
|---|---|
| ▪ Encouragement to continue - self-belief<br>▪ Reduce feelings of isolation<br>▪ Debriefing, particularly of negative or challenging experiences<br>▪ Access to a neutral person who is confidential and objective<br>▪ Access to others' lived experiences - "been there, done that"<br>▪ Consistent relationship with a person who is reliable, grounded, knowledgeable, a good communicator, has a balanced approach and is an Aboriginal and Torres Strait Islander person with cultural understanding of what students face<br>▪ Career advice – financial, resources, support structures, how to apply for jobs (although need to consider what role universities play in preparing students), etc.<br>▪ Support in problem-solving and strategising<br>▪ Post grad: Access to specific expertise through the mentor or mentor's networks<br>▪ Clear boundaries with other support services, e.g. academic and financial support<br>▪ Comfort of knowing support is there, have a choice to opt in and out, i.e. it is voluntary and there is a choice of mentor<br>▪ Build a culture of mentoring being normal and OK, and how it sits in a cultural context for Aboriginal and Torres Strait Islander Australians<br>▪ Access to a skilled mentor, someone who is trained and understands their role<br>▪ Time to develop a relationship and find a connection (a matching process)<br>▪ Coping with racism in university and clinical placements – how to respond | |
| **Successes of previous program** | **Challenges of previous program** |
| ▪ Word of mouth<br>▪ Conferences – good opportunity to network and meet 'mentors'<br>▪ Willingness of mentors to provide support to students | ▪ Low number of CATSINaM Members<br>▪ Resources<br>▪ Isolation<br>▪ Costs (i.e. membership fee)<br>▪ Student willingness to participate<br>▪ Time to provide mentoring<br>▪ Marketing – not well known |

| Enablers for future program | Barriers for future program |
|---|---|
| ▪ Creating a good marketing strategy<br>▪ Knowledge and expertise from staff, committee members and our advisors<br>▪ Strategic Direction: Our vision and purpose is sound and supported by funding bodies<br>▪ Development of a mentoring training program<br>▪ Willingness of mentors/members – use of Conference to support program<br>▪ CPD hours for training and mentoring<br>▪ Steering Communication review – the effort to formalise and structure it<br>▪ Accredited training options available, i.e. units of competency in mentoring<br>▪ Can draw on previous work on mentoring for Aboriginal health professionals<br>▪ Grounded in a thorough member consultation – directly responding to member identified need | ▪ Poor marketing<br>▪ Inappropriate systems<br>▪ Overlapping (both barriers and access to other programs)<br>▪ Distance due to location of mentors and mentees<br>▪ Cost (not part of our current core funding)<br>▪ Training being accessible |

## Table 2: Graduates and early career nurses and midwives

<table>
<tr><th colspan="2">Needs</th></tr>
<tr><td colspan="2">
<ul>
<li>Debriefing, particularly of negative or challenging experiences</li>
<li>Share experiences to reflect on successes – recognition and encouragement</li>
<li>Job interview skills</li>
<li>Career progression and options – clinical areas, different ideas</li>
<li>Isolation as a graduate, particularly cultural isolation if in non-Indigenous organisations</li>
<li>Coping with racism in the workplace from colleagues, clients and patients</li>
<li>Developing resilience</li>
<li>Understanding and addressing inappropriate expectations, i.e. of other staff to be a ‘cultural resource’</li>
</ul>
</td></tr>
<tr><th>Successes of previous program</th><th>Challenges of previous program</th></tr>
<tr><td>
<ul>
<li>None identified by group</li>
</ul>
</td><td>
<ul>
<li>Inappropriate matching</li>
<li>Poor uptake of mentors and mentees</li>
<li>Unknown – poor marketing</li>
<li>Unstructured</li>
</ul>
</td></tr>
<tr><th>Enablers for future program</th><th>Barriers for future program</th></tr>
<tr><td>
<ul>
<li>Marketing and promotion</li>
<li>Payment incentive for mentor i.e. cost of phone calls</li>
<li>CPD hours for training and mentoring</li>
<li>Willingness of members and organisation - “beyond lip service”</li>
<li>Securing dedicated funding</li>
<li>Up-skilling in mentoring through training</li>
<li>Accredited training options available – units of competency in mentoring</li>
<li>Can draw on previous work on mentoring for Aboriginal health professionals</li>
<li>Grounded in thorough member consultation – directly responding to member identified need</li>
</ul>
</td><td>
<ul>
<li>Distance</li>
<li>Poor marketing - poor up take</li>
<li>Communication - access to IT</li>
<li>Cost (not part of our current core funding)</li>
</ul>
</td></tr>
</table>

## Table 3: Mid-career nurses and midwives

| Needs |
| --- |
| ▪ Broad range of needs that are health sector, opportunity and role dependent<br>▪ Career progression and options<br>▪ May have very specific needs, e.g. research, management and supervision, etc.<br>▪ Coping with racism in the workplace from colleagues, clients and patients<br>▪ Returning to work – regaining registration<br>▪ Building culture of going into research and academic teaching – Phase 2 in MP<br>▪ Risk of burnout |

## Table 4: Later career nurses and midwives

| Needs |
| --- |
| ▪ Looking for a change of direction, i.e. going into research, policy or academia<br>▪ Broad range of needs but likely to be specific needs, more commonly related to administration, management, policy and project space than other groups<br>▪ Coping with racism in the workplace from colleagues, clients and patients (may be in senior levels of organisations)<br>▪ Risk of burnout<br>▪ How to stay involved if considering retirement |

# Looking beyond CATSINaM

## What can we learn from others' experiences?

Previous or current mentoring programs for Aboriginal and Torres Strait Islander health professionals operated by similar national organisations were identified and reviewed to provide direction on how CATSINaM could reshape its program.

The National Aboriginal Community Controlled Health Organisation (NACCHO) has recently trialled a mentoring program for Aboriginal and Torres Strait Islander Health Workers specialising in ear and hearing health, and both the Indigenous Allied Health Association (IAHA) and the Australian Indigenous Doctors' Association (AIDA) have explored and are operating mentoring options, although they are in their early stages. The National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) do not have a mentoring program in place, although they intend to develop one over the next two years.

### Indigenous Allied Health Association

IAHA currently operates their mentoring program on a voluntary basis with students as the target group. Potential Mentors register online and provide an overview of their skills and strengths. Potential Mentees also register online and can access the list of available Mentors. The matching process occurs on the basis of self-selection initiated by students. Students notify IAHA that they have identified a potential Mentor, then IAHA contacts that person to advise that a student has requested their support. Once this is accepted by the potential Mentor, the student makes direct contact and the Mentor-Mentee relationships commences.

The mentoring arrangement is informal, but an agreement between Mentor and Mentee outlining expectations and arrangements is signed. Contact occurs predominantly by email and phone. To date the longest mentoring relationship is six months, but many are of a very short duration.

Training is not provided to Mentors, although resources are provided to assist them in the process. IAHA is currently developing cultural resources to assist non-Aboriginal Mentors who have registered with them.

Currently the program has many potential Mentors registered, but not many Mentees as take up has been low. IAHA have recently implemented the following strategies to improve student knowledge of this opportunity:

- They established a student body within IAHA membership, which started with a leadership forum in 2013.
- They initiated a Health Fusion Team Challenge 2013, which creates teams of different health professionals who work through care issues and arrangements for real life

scenarios in order to foster cross-health professional collaboration. They will hold another in Nov 2014.

## Australian Indigenous Doctors Association

AIDA has a Mentoring Framework which is relatively new, released in 2012, which outlines the roles and responsibilities of AIDA, medical schools, postgraduate medical councils and councils, Mentors and Mentees. Mentoring is also embedded in the Collaborative Agreements that AIDA has with the Medical Deans of Australia and New Zealand, Committee of Presidents of Medical Colleges and Confederation of Postgraduate Medical Education Councils (CPMEC). Although this foundation is in place, an actual mentoring program is yet to be initiated.

The intention is that a mentoring relationship will be instigated within AIDA or be provided externally by other organisations. For example if a mentor is not available within AIDA's membership, they will utilize members from the RACGP (Royal Australian College of General Practitioners) Indigenous Health Faculty as they have 3,500 members to draw upon.

AIDA intends to run the program on a voluntary basis as it is seen as providing participants with intrinsic rewards. AIDA will undertake the matching, introduction and agreement signing process, including re-matching if required. After that, they expect the Mentor and Mentee to form and carry out their relationship without assistance from AIDA.

At this stage there is no plan to provide training to Mentors, however the next AIDA Symposium will have a workshop on Mentoring. The existing Medical Colleges also provide mentoring training, so existing training options are available to doctors.

AIDA is also developing an application for RACGP to be a CPD accredited provider, which may enable them to have a broader scope of work, including work on mentoring. CPD is a formalised process for the medical profession and works on a points system.

AIDA is developing online forums through their Intranet for students, graduates, and directors that will enable each group to network. They also envisage that each forum may have topics of interest that will run for a week with an expert in the field moderating the forum. There will be no anonymity in the forums, so there is an expectation that participants will always be professional.

Another strategy that AIDA is exploring is a 'Buddy System' for conferences and symposiums run either by AIDA or other medical groups. A student will be linked with a qualified medical practitioner who will provide support, introductions and guidance during the event. It is a way of 'breaking the ice' and assisting students to build professional relationships.

AIDA also indicated that Flinders University has an Indigenous Mentoring Program which is perceived to be successful and is not just for doctors. CATSINaM will approach them to see whether they can share further details with us. Together with their initial developmental

work and what AIDA has learned from Flinders University, the lesson learned so far is that Mentoring works best if done at the local level, i.e. Mentors and Mentees can have face-to-face contact relatively easily.

## National Aboriginal Community Controlled Health Organisation

In 2013, NACCHO trialled a national mentoring program for Aboriginal Health Workers that specifically focused on ear and hearing health. This was a structured mentoring program based on formal agreements that all parties signed – the mentor, the mentor's employer, the mentee and the mentee's employer – which NACCHO co-signed. Mentors were Aboriginal Health Workers who were experienced in ear and hearing health, not necessarily in Senior Aboriginal Health Worker or specialist Ear and Hearing Health Worker positions. Mentees were relatively or completely new to the ear and hearing health field, but had recently completed an accredited national skill set in ear and hearing health, although they may have considerable experience as an Aboriginal Health Worker overall.

A financial incentive was provided to the mentor's employer to support their release from work duties in order to be available to provide a series of six mentoring sessions of approximately one hour duration. No financial incentive was provided to the Mentee's employer as they were gaining the benefit of free professional development for their staff member. The travel costs of both Mentors and Mentees to attend all mentoring program events were funded, although employers paid a travel allowance for their employees.

An orientation workshop was held prior to potential Mentors, Mentees and their employers signing a formal agreement. Training was offered to both the Mentors and Mentees to commence the program, through which a matching process occurred. As this was a national program with a small number of places (up to 10 in total although six were sustained across the entire program), Mentors and Mentees were often a long distance apart. Therefore, most mentoring occurred via phone and email, with occasional face-to-face opportunities. After the six sessions, there was a program review workshop that included a formal evaluation session, and all participants were funded to attend it. This was co-timed with a National Ear and Hearing Health Symposium that all participants also attended.

The evaluation outcomes indicated that overall the mentoring program had many successes in enhancing the confidence of Aboriginal Health Workers new to ear and hearing health, and supporting them in applying and improving their newly acquired skills. Mentoring over a long distance was a challenge, and all Mentor/Mentee pairs were keen to have more face to face time, particularly in each other's regular working environments. However, all participants believed there were strong grounds for it to continue based on both ongoing need and the program's success.

Factors that supported success included: access to formal training, the mentoring handbook, formal 'whole of group' meetings that provided opportunities for peer support amongst Mentors, the enthusiasm and commitment of Mentors, the long-standing

experience of Mentors, and shared cultural identity between Mentor and Mentee. Improvements identified included: a longer period for mentoring (time and number of sessions), more face to face opportunities to reduce the tyranny of distance, and stronger employer support for participation in the program.

The overall National Ear and Hearing Health Training for the Aboriginal Health Worker Workforce finished in November 2013. At this point it is uncertain whether funding can be secured for it to continue, whether managed by NACCHO or another suitable body.

## CRANAplus

CRANAplus is a national organisation, but is not specifically focused on supporting Aboriginal and Torres Strait Islander health professionals. Its core business is to "Educate, Support and Advocate for all health professionals working in the remote sector of Australia". It has developed and operated a formal mentoring program for a few years, so can provide CATSINaM with information that is worthy of consideration.

The purpose of the CRANAplus Mentoring Program is to provide support and mentorship for new graduates to remote practice, whether they are a recent graduate or an experienced professional. It also provides current health professionals in remote practice with knowledge and skills required to provide effective mentoring, and transferrable skills they can utilise every day in their own practice.[1] It is a voluntary program, as CRANAplus believes mentoring is the professional responsibility of the individual, however they provide in-kind support through the mentoring program.

The program provides relevant knowledge and skills to both the Mentor and Mentee, through a Continuous Professional Development activity that is accessible on its eRemote website, and a coordinated and supported mentoring program that links experienced Mentors with Mentees. They have an online Program Coordinator who provides support for the online module, and develops the mentoring relationship with the assistance of Bush Support Services through regular contact, including use of telephone, e-mails and Skype.

Mentors and Mentees are required to enter into a formal agreement for the duration of the mentoring process with CRANAplus, and are also guided by a 'statement of duties'. Although CRANAplus is a member-based organistions, the Mentee and Mentor do not have to be a member of CRANAplus prior to joining program (this reflects their conditions of funding i.e. to support health professionals in remote Australia). Interested individuals complete a registration form and undertake a reference check. They are also expected to complete the online training module prior to being allocated as a Mentee or Mentor.

[1] See: <https://crana.org.au/education/remote-and-rural-mentoring-program>.

In addition to ongoing monitoring and support an evaluation framework is embedded into the CRANAplus Mentoring Program. This includes a monitoring system through regular contact from the Program Coordinator with Mentors and Mentees that occurs at four, eight and then twelve weeks into a mentoring relationship by phone of Skype. Then there are formal evaluation surveys to complete at the three, six and twelve month points.

The reported outcomes of the program are:

- demonstration of an understanding of the skills and knowledge required for mentoring
- participation in a mentoring relationship as a mentor or a mentee
- development of an appreciation of the benefits of mentoring in remote practice
- development of skills in implementing and advocating for mentoring programs in the workplace for recruitment and retention of remote staff
- networking opportunities through mentoring relationship and access to CRANAplus activities and resources

Through direct liaison with CRANAplus, CATSINaM learned that CRANAplus is interested in talking further about whether there is potential for collaboration with CATSINaM with the new Mentoring Program.

# How can the literature and existing data guide us?

It is clear that mentoring in general has become a very popular strategy in Australia, as is evident if you Google "mentoring in Australia'. It has commonly been used to support young people who are deemed 'at risk' in some way, e.g. in completing their education, in being caught in the criminal justice system and/or in being embroiled in an illicit drug-taking culture etc. At times, these programs are solely focused on or give high priority to Aboriginal and Torres Strait Islander Australians. Mentoring has also been applied within health promotion and prevention programs in Aboriginal health contexts. Many of these programs are government funded, or run through charity organisations based on their fund-raising revenue.

When mentoring occurs in a workforce context, programs range from supporting young people to complete their apprenticeships, human resource practitioners to progress their careers, or up-skilling professional peers in a new specific area of health, e.g. ear and hearing health, health promotion, palliative care, cancer care etc.

## Literature on mentoring in Aboriginal health contexts

There is very limited information on mentoring for the Aboriginal health workforce, although it is an area of high interest, as evident by the level of engagement with mentoring in some form by national Aboriginal health organisations. Only some of the

mentoring programs mentioned above are specifically focused on providing cultural support and facilitating retention of Aboriginal employees. For example, this one comes from a health context:

> *"Mentoring has also been recognised as playing a significant role more broadly in staff support. Most employees need to be nurtured and supported to perform at their best. From our experience this need can be even greater in Aboriginal employees, particularly when working within a traditionally mainstream organisation."(p.F)*[2]

Unfortunately, almost no published material exists on ***formal*** mentoring programs for Aboriginal and Torres Strait Islander health professionals, let alone Aboriginal and Torres Strait Islander nurses and midwives. The one publication identified focused on a two-way mentoring program between Aboriginal Health Workers (AHWs) and allied health professionals, where AHWs were upskilled in relevant allied health knowledge and skills to facilitate more effective multi-disciplinary work, and allied health professionals (who were non-Aboriginal) gained cultural mentoring to improve the cultural safety of their practice.[3] This has a different focus to what CATSINaM seeks to achieve in their mentoring program.

In talking about the potential for mentoring within nursing, Gilly Johnson acknowledges that mentoring as a concept and practice is very old. She describes the phenomenon of "modern mentoring" as encompassing:

- *The 'core' of mentoring – the relationship*
- *The 'role' of mentoring – sense of purpose and offline*
- *The 'skill set' of mentoring – new skills required for structured mentoring*
- *The 'framework' of mentoring – how it is facilitated to happen*[4]

She is now the Director of The Mentoring Resources Hub, which may be a useful resource for the new CATSINaM program (http://www.mentoringresourceshub.com.au). She also referred to the International Standards for Mentoring Programmes in Employment (ISMPE) as a guide in both designing and assessing workplace programs. They are: "clarity of

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[2] Wood, L, Shilton, T, Dimer, L, Smith, J & Leahy, T, 2011, Beyond the rhetoric: how can non-government organisations contribute to reducing health disparities for Aboriginal and Torres Strait Islander people? *Australian Journal of Primary Health*, published 15 November 2011, viewed April 3, 2014 <http://www.mckeonreview.org.au/sub/ 333Att1.pdf>.

[3] 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, pp 457-462.

[4] Johnson, G, 2005, *Mentoring for nurses in general practice – opportunities and challenges*, viewed April 3, 2014 <http://www.thesandsingpframework.com/documents/rd/Mentoring-for-nurses-in-general-practice---opportunities--and--challenges.pdf>.

purpose, stakeholder training and briefing, processes for selection and matching, processes for measurement and review, maintains high standards of ethics, and administration and support".[5]

Other resources exist based on Australian work focused on establishing or strengthening mentoring practice and models within nursing. However, few consider culture, cultural safety and racism as part of the mentoring context, or as contributing to recruitment and retention issues in the workforce. Examples do exist of viewing mentoring as a key strategy for supporting nursing students make the critical transition from student to graduate in their final year of study, and feeling confident and competent in the workplace.[6] Other publications clarify the specific role that mentoring can and does play in nursing compared with other common practices such as supervision and preceptoring – for example:

> *"Mentoring is broadly based and concentrates on developing areas such as career progression, scholarly achievements and personal development. Clinical supervision focuses on progressing clinical practice through reflection and the provision of professional guidance and support. Preceptorship focuses on clinical skill acquisition and socialisation….Mentoring relationships are based around developing reciprocity and accountability between each partner. They are normally conducted outside the work environment and in the participant's own time." (p.1)*[7]

The authors go on to point out that clinical supervision and preceptoring relationships typically occur within the work environment. The concept of mentoring they described aligns with the intentions of the CATSINaM program. A major piece of work focused on mentoring for nurses in general practice produced a series of fact sheets that could be drawn upon and adapted as part of a more comprehensive CATSINaM mentoring handbook, although there is no cultural content as cultural identity was not a consideration in that initiative. This study concluded that "the success of mentoring for nurses in general practice is likely to be enhanced by appropriate resourcing and infrastructure to develop awareness of and commitment to flexible and accessible mentoring for nurses in general practice" (p.6).[8] The emphasis on resourcing and infrastructure provides direction for a revised CATSINaM program becoming more formal and better coordinated, ensuring it is adequately resourced, and being open to more than one model of mentoring.

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[5] Viewed April 3, 2014 <http://www.ismpe.com/uploads/1/9/3/8/19389975/ismpe_outline_1.pdf>.

[6] Theobold, K & Mitchell, M, 2002, Mentoring: improving transition to practice, *Australian Journal of Advanced Nursing*, 20:1, pp.27-33.

[7] Mills, J, Francis, K & Bonner, A, 2005, Mentoring clinical supervision and preceptoring: clarifying the conceptual definitions for Australian rural nurses. A review of the literature, *Rural and Remote Health*, 5:3, pp. 1-10.

[8] Heartfield M, Gibson T, Chesterman C & Tagg L, 2005, *'Hanging from a string in the wind': Development of a National Framework for Nurses in General Practice Final Report*. Department of Health and Ageing, Canberra.

## Relevant data

Data on Aboriginal and Torres Strait Islander nurses and midwives in the workforce was obtained from Health Workforce Australia (HWA) for 2012 and is shown in Tables 5 and 6; 2013 data is not yet available. It is from the National Health Workforce Data Set collected by the Australian Institute for Health and Welfare (AIHW). Of note is the last row in both tables that shows the percentage of employed Aboriginal and Torres Strait Islander nurses and midwives as a proportion of the entire employed workforce. This underscores the need to find effective strategies to support recruitment and retention of Aboriginal and Torres Strait Islander nurses and midwives in the workforce.

The available national data related to students in courses at higher education institutions leading to initial registration as a nurse or a midwife is sourced from the Commonwealth Department of Education's Higher Education Statistics Collection and provided by HWA. Nursing data is shown in raw number form here only in Table 7, as it was not available based on following cohorts of students over time to calculate accurate retention and completion rates. HWA advised there is no definitive information or data available regarding student attrition rates, particularly as there are different definitions used by various organisations. Data on student midwives in Table 8 is even more limited, with only commencement and completion numbers available.

However, there is another source of information – see Figure 1.[9] While a few years old, a recent publication based on research undertaken by a CATSINaM Member, Professor Roianne West, into the completion rates for pre-registration nursing courses provides an insight into the substantial difference in completion rates for Aboriginal and Torres Strait Islander nursing students compared to non-Indigenous students.

As there has been limited change in the range of strategies employed by universities over the last decade, it is likely that the current situation may be the same although that would be valuable to verify. The recently revised ANMAC (Australian Nursing and Midwifery Accreditation Council) standards for nursing and midwifery courses, which now have clearer expectations for universities to recruit and support Aboriginal and Torres Strait Islander students, may contribute to improvement provided that explicit direction and guidance is provided, including models of good practice. An effective mentoring program would be an essential strategy – this was recommended by CATSINaM in 2002 when they reviewed what universities were doing at that time to support recruitment and retention of Aboriginal and Torres Strait Islander nursing and midwifery students.[10]

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[9] West, R, Buttner, P, Foster, K, Usher, K & Stewart, L, 2013, Indigenous Australians' participation in pre-registration tertiary nursing courses: A mixed methods study, *Contemporary Nurse*, Aug 4. [Epub ahead of print].

[10] CATSIN, 2002, *'Gettin em n keepin em': Report of the Indigenous Nursing Education Working Group*, Commonwealth of Australia, Canberra.

**Table 5: Number of employed registered and enrolled NURSES (and midwives) by Aboriginal and Torres Strait Islander Status, 2012**

| | NSW | VIC | QLD | SA | WA | TAS | NT | ACT | National (b) |
|---|---|---|---|---|---|---|---|---|---|
| **Registered nurse only** | | | | | | | | | |
| Indigenous | 441 | 179 | 342 | 93 | 85 | 68 | 43 | 22 | 1,272 |
| Non-Indigenous | 59,418 | 53,741 | 40,682 | 18,105 | 22,409 | 5,317 | 2,783 | 3,455 | 205,924 |
| Not stated/inadequately described | 179 | 127 | 111 | 54 | 54 | 7 | 10 | 16 | 557 |
| **Registered nurse and midwife** | | | | | | | | | |
| Indigenous | 73 | 16 | 47 | 12 | 23 | 3 | 0 | 5 | 180 |
| Non-Indigenous | 8,968 | 7,535 | 5,692 | 2,112 | 2,628 | 579 | 517 | 549 | 28,581 |
| Not stated/inadequately described | 32 | 22 | 20 | 6 | 15 | 3 | 0 | 0 | 98 |
| **Total registered nurses** | | | | | | | | | |
| Indigenous | 515 | 194 | 389 | 105 | 107 | 71 | 45 | 27 | 1,452 |
| Non-Indigenous | 68,386 | 61,276 | 46,374 | 20,217 | 25,037 | 5,895 | 3,300 | 4,003 | 234,504 |
| Not stated/inadequately described | 211 | 148 | 130 | 60 | 69 | 8 | 10 | 18 | 655 |
| **Enrolled nurse only** | | | | | | | | | |
| Indigenous | 346 | 113 | 195 | 75 | 50 | 30 | 9 | 11 | 829 |
| Non-Indigenous | 11,313 | 17,033 | 9,206 | 6,770 | 4,230 | 1,107 | 347 | 624 | 50,631 |
| Not stated/inadequately described | 41 | 36 | 19 | 21 | 12 | 8 | 0 | 0 | 139 |

| | NSW | VIC | QLD | SA | WA | TAS | NT | ACT | National (b) |
|---|---|---|---|---|---|---|---|---|---|
| **Enrolled nurse and midwife** | | | | | | | | | |
| Indigenous | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Non-Indigenous | 4 | 15 | 0 | 4 | 0 | 0 | 0 | 3 | 25 |
| Not stated/inadequately described | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total enrolled nurses** | | | | | | | | | |
| Indigenous | 346 | 113 | 195 | 75 | 50 | 30 | 9 | 11 | 829 |
| Non-Indigenous | 11,318 | 17,048 | 9,207 | 6,774 | 4,230 | 1,107 | 347 | 626 | 50,656 |
| Not stated/inadequately described | 41 | 36 | 19 | 21 | 12 | 8 | 0 | 0 | 139 |
| **Total nurses** | | | | | | | | | |
| **Indigenous** | **861** | **307** | **583** | **180** | **157** | **101** | **54** | **38** | **2,281** |
| **Non-Indigenous** | 79,704 | 78,324 | 55,581 | 26,991 | 29,266 | 7,002 | 3,647 | 4,629 | 285,160 |
| **Not stated/inadequately described** | 253 | 184 | 150 | 81 | 82 | 17 | 10 | 19 | 794 |
| ***% of employed nurses who are Indigenous (a)*** | ***1.1*** | ***0.4*** | ***1.0*** | ***0.7*** | ***0.5*** | ***1.4*** | ***1.5*** | ***0.8*** | ***0.8*** |

**NOTES**

a) Percentage of Indigenous nurses employed excludes those in the not stated category.

b) Includes those who did not state or adequately describe their location, and those who reside overseas. Therefore states and territories may not sum to Australia total.

c) Cells in this table have been randomly adjusted to avoid the release of confidential data.

## Table 6: Number of employed MIDWIVES by Aboriginal and Torres Strait Islander Status, 2012

| | NSW | VIC | QLD | SA | WA | TAS | NT | ACT | National (b) |
|---|---|---|---|---|---|---|---|---|---|
| **Dual registered nurse and midwife** | | | | | | | | | |
| Indigenous | 73 | 16 | 47 | 12 | 23 | 3 | 3 | 5 | 180 |
| Non-Indigenous | 8,973 | 7,549 | 5,693 | 2,116 | 2,628 | 579 | 517 | 550 | 28,606 |
| Not stated/inadequately described | 32 | 22 | 20 | 6 | 15 | 0 | 0 | 0 | 98 |
| **Midwife only** | | | | | | | | | |
| Indigenous | 4 | 7 | 3 | 0 | 0 | 0 | 3 | 0 | 19 |
| Non-Indigenous | 353 | 633 | 290 | 306 | 205 | 12 | 36 | 48 | 1,886 |
| Not stated/inadequately described | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 3 |
| **Total midwives** | | | | | | | | | |
| **Indigenous** | **78** | **22** | **50** | **14** | **24** | **3** | **4** | **5** | **200** |
| **Non-Indigenous** | 9,326 | 8,183 | 5,983 | 2,423 | 2,833 | 590 | 553 | 598 | 30,492 |
| **Not stated/inadequately described** | 33 | 22 | 20 | 7 | 15 | 0 | 0 | 3 | 100 |
| ***% of employed midwives who are Indigenous (a)*** | ***0.8*** | ***0.3*** | ***0.8*** | ***0.6*** | ***0.8*** | ***0.5*** | ***0.7*** | ***0.8*** | ***0.7*** |

**NOTES**

a) Percentage of Indigenous midwives employed excludes those in the not stated category.

b) Includes those who did not state or adequately describe their location, and those who reside overseas. Therefore states and territories may not sum to Australia total.

c) Cells in this table have been randomly adjusted to avoid the release of confidential data.

**Table 7: Number of student commencements, completions and continuing students by Indigenous status, 2007 to 2012 - Students in courses required for initial registration as a nurse**

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|
| **Commencements** | | | | | | |
| Indigenous | 201 | 218 | 244 | 304 | 334 | 358 |
| Non-Indigenous | 13,168 | 13,326 | 14,896 | 16,056 | 15,674 | 17,103 |
| Not stated/Inadequately described | 65 | 54 | 92 | 268 | 330 | 329 |
| **Total** | **13,434** | **13,598** | **15,232** | **16,628** | **16,338** | **17,790** |
| **Continuing** | | | | | | |
| Indigenous | 293 | 340 | 375 | 415 | 454 | 522 |
| Non-Indigenous | 20,851 | 22,782 | 23,825 | 25,873 | 28,246 | 29,597 |
| Not stated/Inadequately described | 293 | 238 | 227 | 176 | 328 | 417 |
| **Total** | **21,437** | **23,360** | **24,427** | **26,464** | **29,028** | **30,536** |
| **Completions** | | | | | | |
| Indigenous | 61 | 69 | 92 | 96 | 90 | 103 |
| Non-Indigenous | 7,772 | 8,644 | 8,800 | 9,272 | 9,931 | 10,433 |
| Not stated/Inadequately described | 91 | 73 | 116 | 77 | 51 | 99 |
| **Total** | **7,924** | **8,786** | **9,008** | **9,445** | **10,072** | **10,635** |

**Table 8: Number of Indigenous student commencements and completions within the midwifery field of education by course type and characteristics, Australia, 2007 to 2012**

| | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|
| **Commencements** | | | | | | |
| Bachelor | 11 | 13 | 13 | 37 | 40 | 28 |
| Postgraduate | 12 | 7 | 9 | 8 | 12 | 7 |
| **Total** | **23** | **20** | **22** | **45** | **52** | **35** |
| **Completions** | | | | | | |
| Bachelor | 3 | 0 | 3 | 3 | 8 | 11 |
| Postgraduate | 12 | 7 | 3 | 4 | 9 | 0 |
| **Total** | **15** | **9** | **6** | **7** | **17** | **12** |

**NOTES**

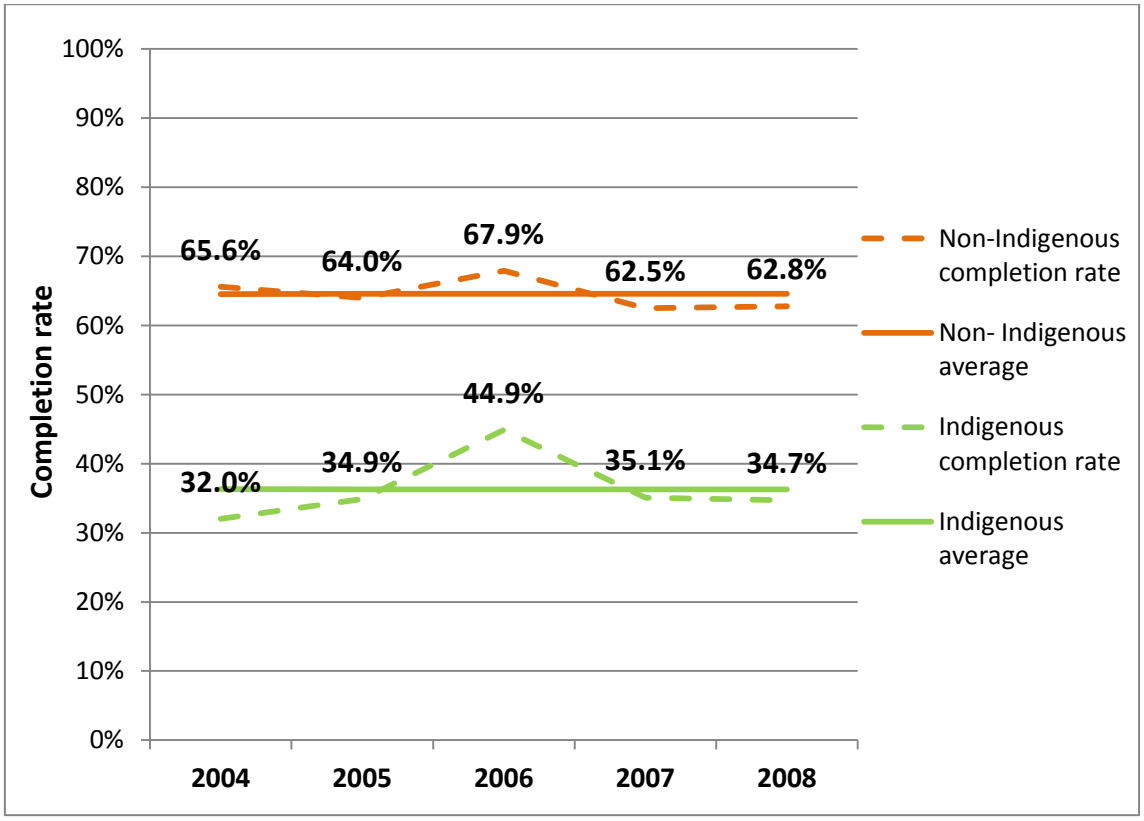
These tables present data from the Department of Education's Higher Education Statistics Collection. This provides a range of information on the provision of higher education in all Australian universities. From this collection, information is available on the number of student commencements and completions in higher education courses allocated to the midwifery field of education, as well as the characteristics of those students. The term Indigenous reflects the terminology used in the source data. Cautions to note with the Department of Education data:

- Information may include courses allocated to the midwifery field of education that do not lead to registration as a midwife. That is, it may include students in non-accredited courses.

- The accuracy of coding courses to field of education is the responsibility of each university, and is subject to the knowledge of those allocating the codes.

- Information includes combined courses where the course has been allocated to two fields of education. Combined courses are courses designed to lead to a single combined award or to meet the requirements of more than one award.

**Figure 1: National nursing completion Rates: Pre-registration tertiary nursing courses - Indigenous/non-Indigenous comparison by year**




## What funding options exist?

Several funding options were explored to identify whether they could assist with training Mentors and/or implementing the mentoring program:

- Workforce Development Fund – no details are available on how this will operate in the current or future financial years. This will need to be reviewed after the Federal Budget announcements in May 2014.
- ITAS – Tertiary and VET: Having consulted the Industry, Education and Prime Minister and Cabinet departmental websites, no details are available on how this will operate in the current or future financial years. This will need to be revisited after the Federal Budget announcements in May 2014.
- ANMAC: Funding is not available from ANMAC. Their approach to Assessors who sit on Accreditation Committees is to provide an honorarium payment that offsets costs associated with attending a site visits (such as meals, incidentals, motor vehicle allowance, taxi fares and parking etc.), as well as preparatory work such as participating in teleconferences. If the Assessor is paid while on accreditation duties, then the employer can submit a claim to cover the incidental costs instead of the Assessor.

- State and Territory Departments: Work is still underway to identify whether there are any funding or co-funding options within state and territory health departments and will take some time to complete. Rather than delay the progress of the review the information gathered from Victoria will be presented and communication with the other jurisdictions will continue to be pursued.

  VicHealth have finalised its Koolin Balit Aboriginal Health Workforce Program 2013-2017. Projects in 2013-14 include:

  - The Koolin Balit Aboriginal Health Workforce Training Grants 2013-14 - Round 1 has allocated 36 training grants including nursing, allied health, primary health, management and alcohol and other drugs, to up-skill existing Aboriginal workers and stimulate traineeships to grow the Aboriginal health workforce.
  - A new statewide project is underway - *Implementation of Aboriginal Employment Plans (AEPs) in Public Health Services*. This project will support up to 32 health services with 500 staff or more to implement their AEPs over 2013-14 and 2014-15.
  - The *Aboriginal Community Controlled Health Organisations (ACCHOs) Human Resource Capacity Project* has commenced to strengthen human resource capacity in small to medium sized ACCHOs, and establish a HR 'community of practice' network for all Victorian ACCHOs. The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) is leading this project.
  - The continuation and expansion of the *Victorian Aboriginal Nursing, Midwifery and Allied Health Cadetship program* in selected health services (metro and rural). A minimum of 15 cadetships will be supported in 2014.
  - A new program commencing in 2014, the *Aboriginal Nursing and Midwifery Graduate Program,* is being established in selected health services with a minimum of five places in 2014.
  - VicHealth has also supported three INTRAIN Scholarships in nursing and midwifery undergraduate and post graduate qualifications for 2014.

  While mentoring is not specifically mentioned, this raft of programs suggests there may be possibilities for discussions with VicHealth about how mentoring plays a role within one or more of these programs, e.g. the AEPs, cadetships and scholarships, and what collaboration could occur with CATSINaM to fund a mentoring program in Victoria.

# What Aboriginal health workforce targets or policy positions do states and territories have?

Efforts were made to identify Aboriginal health workforce targets for each State/Territory relating to recruitment and retention of Aboriginal and Torres Strait Islander peoples in the workforce. In all documents searched there was no mention of targets outside of the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (NATSIHWSF) 2011-2015 and its related performance framework. NATSIHWSF references the National Health Performance Framework 2009 for its employment KPI (updated in 2011), which also defines the employment target of 2.6% included in the Australian Health Care Agreements with states and territories. This target was guided by the available population data at the time and is consistent with the 2010 National Partnership Agreement on Indigenous Economic Participation. All states and territories are represented on ATSIHWWG and signatories to the NATSIHWSF.

In addition, the Department of Health in South Australia is subject to South Australian's Strategic Plan 2007. It includes a target of achieving 2% participation of Aboriginal people in the South Australian public sector across all classifications and agencies by 2010, and to maintain or better those levels through to 2014 (Target 6.24: Aboriginal employees).

In terms of relevant policy documents, Table 9 provides a summary of the current status. Only ACT and WA have current Aboriginal and Torres Strait Islander Nursing and Midwifery Frameworks, although NSW and VIC are in the process of developing one. While SA and QLD have overall Nursing and Midwifery Frameworks, no specific mention is made of Aboriginal and Torres Strait Islander nurses and midwives. The overall Aboriginal and Torres Strait Islander Health Plans that exist in almost all jurisdictions focus on how health outcomes will be improved, with minimal or no detail on workforce matters.

**Table 9: Jurisdictional policy documents**

| Type of document | ACT | NSW | NT | QLD | SA | TAS | VIC | WA |
|---|---|---|---|---|---|---|---|---|
| Aboriginal and Torres Strait Islander Nursing & Midwifery Framework | ✓ | Draft | | | | | Draft | ✓ |
| Overall Nursing & Midwifery Framework | | | | ✓ | ✓ | | | |
| Overall Aboriginal and Torres Strait Islander Health Plan | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Aboriginal and Torres Strait Islander Health Workforce Plan | | Draft | | | ✓ | | | |

It appears that there is only one Aboriginal and Torres Strait Islander Health Workforce Plan in SA, although its end-date was 2013 and it could not be confirmed whether it is being extended or updated at this point, but NSW are also developing one.

## How does the nursing and midwifery CPD points system apply to the mentoring program?

The Nursing and Midwifery Board of Australia does not accredit any CPD activities or providers. Nurses and Midwives are not limited to CPD offered by specific providers – they have the flexibility to choose the CPD options that best suit their own needs, including activities offered by overseas CPD providers.

Nurses and Midwives are not to contact the Board to request approval of a specific CPD activity. Instead they must their use own professional judgment to make an assessment of whether the CPD activity is directly related to their Nursing and/or Midwifery practice, i.e. enhancing their practice, and their ***personal learning plan***. Nurses and Midwives may be asked to justify CPD hours on this basis, so it would be important for mentoring activity to be formally documented. The CPD requirements for maintaining registration are as follows:

- Nurses on the nurses' register will participate in at least ***20 hours*** of continuing nursing professional development per year.
- Midwives on the midwives' register will participate in at least ***20 hours*** of continuing midwifery professional development per year.
- Registered nurses and midwives who hold scheduled medicines endorsements, or endorsements as nurse or midwife practitioners under the National Law, must complete at least an ***additional 10 hours*** per year in education related to their endorsement.

# Considerations for a revised program

The previous section raises a number of issues that CATSINaM needs to consider and, where possible, address in revising and expanding the current program in line with the recommendations from Members, the experience of other programs, and the characteristics of the broader environment.

### DO WE EXPECT MENTORS TO VOLUNTEER THEIR TIME?

Carrying out an education role with other nurses is a professional and ethical expectation of all nurses. Volunteering to be a Mentor would meet this expectation. However, there may be other costs associated with adopting this role that need to be considered.

### HOW CAN MENTORS BE RESOURCED, SUPPORTED OR RECOMPENSED FOR VOLUNTEERING?

Several incentives could be provided:

- ***Training in mentoring:*** CATSINaM Members have indicated that mentoring is a high priority topic for professional development, so making training a requirement for volunteering as a mentor has an intrinsic reward.
- ***CPD points:*** Provided that CATSINaM Members who volunteer have identified mentoring as part of their personal learning plan, then the time spent in mentoring training and other whole group mentoring workshops/events can be recorded as CPD hours. It may be possible to include the actual time spent providing and receiving mentoring if it is formally documented as part of the individual's personal learning plan.
- ***Payment of travel costs:*** Travel costs associated with the mentoring program should be built into the budget for the CATSINaM program, i.e. to attend training and other CATSINaM coordinated mentoring workshops/events. This would include flights, accommodation, taxi transfers and meals allowance.
- ***Stipends:*** Other options can be considered for recompense, including offering Mentors the choice of volunteering their time, or:
  - receiving reimbursement of any personal costs (e.g. phone) in addition to travel costs noted through a small annual stipend payment or honorarium per mentee (paid on a quarterly basis once mentoring support has been provided)
  - paying Mentors' employers the stipend for supporting their release of time from work to undertake mentoring support.

### WHAT SHOULD THE PROGRAM SCOPE BE, I.E. HOW SMALL OR BIG DO WE WANT TO START?

Program scope impacts on the costings to include in a proposal. It is likely that program partners and co-funders will need to be sought from individual educational institutions and employers (who operate jurisdictionally and/or locally), particularly as involvement brings

significant benefits for them, i.e. higher retention and completion rates for universities that enhances their funding stream, and better capacity to meet employment targets for state/territory health departments. This suggests that a flexible approach be taken to costing a revised program. Specifically, options based on a 'per/institution' versus 'per/jurisdiction' versus a 'national'; program may be warranted.

We can start with nominating a number of mentoring places, or we could seek to identify potential mentors from CATSINaM Members as this will determine current capacity to support a mentoring program, although one Mentor may nominate that they are available to mentor more than one person. Further, group mentoring options may need to be considered, possibly for students more than graduates.

### HOW SHOULD PARTICIPATION BE DETERMINED - NUMBER OF PLACES, FORMAL CRITERIA?

This is linked to decisions around the scope, i.e. how many co-funding partners are identified, the level of resources available to support mentoring, and the capacity of CATSINaM Members to be Mentors. Discussions will be needed about whether potential Mentees need to meet priority criteria to access places in the program, regardless of whether it operates nationally, jurisdictionally or locally. It is likely that demand will outstrip capacity, so support must go to those who have the least number of alternative options.

In addition, it will be important to set criteria for Mentors, as there are particular qualities required to be an effective mentor, and both CATSINaM and co-funding partners have a duty of care to the people who become Mentees.

### SHOULD A TIME OR 'SESSION' LIMIT BE SET TO FACILITATE WIDER ACCESS?

While the intention is that Mentees have the opportunity to access long-term mentoring, capacity issues are likely to emerge. However, it is also possible that not all mentees will want a long-term arrangement and it does not have to remain a formal arrangement as their needs may change over time. Therefore, the CATSINaM program could offer a period of formal mentoring, after which the Mentor and Mentee can decide if they maintain an ongoing informal mentoring relationship. The latter situation reflects what may happen in the ordinary course of a person following a career pathway.

Therefore, CATSINaM should consider instituting a review process as a central part of the program concept (i.e. at the two month and six month point). This embeds quality assurance within the program, e.g. the quality of the mentoring relationship and if it is an appropriate match so that adjustments can be made to support Mentors/ Mentees at an early point and maintain program integrity. Further, a Mentor or Mentee should know they can discuss the progress of the mentoring relationship at any point with CATSINaM if there is a concern and they want support in deciding how to address it.

### IS THERE A PLACE FOR GROUP MENTORING?

In the case of student nurses and midwives, it is relatively easy to access an entire cohort of students enrolled at a university at one point. So group mentoring options should be

considered, at least as a starting point. This would involve layers of mentoring formality using an 'opt in' system based on relationship development. For example, the mentoring program can be introduced to each cohort of students in their first year as a promotion and early relationship development exercise, or it may involve meeting with all students in a university program early in the university year regardless of where they are in their study. There could be two-three group meetings with the option of formally applying for mentoring support following this, including nominating a preferred Mentor as more than one locally available Mentor would attend the groups. If mentoring is not taken up in one year, students have the option of re-engaging in the following year when the group process is re-instigated.

Returning to the theme of flexibility, the program could be constructed along two streams – a student and a graduate stream – as they have different needs and group mentoring options may prove to be more viable for the student group.

### SHOULD WE ESTABLISH FORMAL CONTRACTS OR AGREEMENTS?

Given the capacity for mentoring training and activity to be eligible for CPD, then it will be important that participants have an easy way of verifying their involvement in this activity. A formal agreement would be part of this, as it would specify the expectations for Mentors to attend training and how many hours of mentoring they will provide, at least in the first instance before a formal review. This would need to be accompanied by a Certificate of Attendance for the training, and a log-book of mentoring sessions. If the Mentee wants to claim this time as CPD, then a formal agreement and log-book will also be needed.

In terms of engaging partners and co-funders in the program, then partnership agreements will definitely be required to formalise the relationship and the in-kind and financial resources that co-funders are contributing.

### SHOULD WE PLAN FOR MENTORING NETWORKING EVENTS AS PEER SUPPORT FOR MENTORS?

The learning from the NACCHO Ear and Hearing Health Mentoring Program was that peer support for Mentors was crucial and needs to be formally facilitated, therefore, this should occur in the CATSINaM program (whether nationally and/or jurisdictionally). Not only will this provide Mentors with a peer support process, provide access to top-up training and double as a quality assurance process, it will also enable CATSINaM to access the 'on the ground' experience of Mentees as they start their study and career pathway.

This latter component will help CATSINaM in its wider raft of work, as it becomes an alternative consultation mechanism. CATSINaM could consider attaching a mentoring event to the Annual Conference, as this will create greater incentive for Members to attend the conference and the progress to date could be formally presented during a plenary conference session. It would also be cost-efficient, particularly if students who receive the existing Conference bursaries also happen to be in the mentoring program.

# Conclusions and recommendations

The conclusions are organised based on critical questions that define the focus and shape of a revised mentoring program. The recommendations that relate to them are in the boxes.

## Who are the priority groups for mentoring?

The high priority groups for a revised mentoring program are student nurses and midwives, and graduates or early career nurses and midwives, i.e. in their first 5 years of practice, as they are the most vulnerable to higher attrition rates from study and the profession. This decision continues the focus of the previous program on students, but extends it to include the graduates/early career group.

The main two reasons for deciding that mid-career and later career nurses and midwives were a lower priority for the mentoring program were because: 1) CATSINaM does and will offer other options that will support their needs, and 2) they will be a likely source of mentors amongst Members. These groups of Members currently or will soon have access to the following professional support options:

- individual advice and referral service (currently available)
- collective advocacy by CATSINaM on issues identified by individual members (currently available)
- a 'job board' on the website to promote existing jobs and opportunities (planned activity for implementation in 2014)
- professional networking meetings, including but not limited to the Annual Conference (both options are currently available, although there are plans to extend professional networking subject to securing further funding)
- professional development opportunities, including formal training in mentoring (a planned activity subject to securing further funding).

However, over time a 'Phase 2' of the mentoring program could be developed that targets very specific needs of mid-career and later-career, e.g. research or academia. This would need to occur on the basis of a successful base program for students and graduates/early career nurses and midwives.

***Recommendation 1: Priority participants***

*Offer the program to student nurses and midwives, and graduates or early career nurses and midwives (in their first 5 years of practice) as the priority participants.*

## Who shares responsibility for the provision of mentoring?

Providing mentoring is not a task for CATSINaM alone. Educational institutions and employers are critical players and must take responsibility in order to meet their key performance indicators – they also benefit from higher recruitment and retention of Aboriginal and Torres Strait Islander nurses and midwives.

- ***Educational institutions*** need to raise their recruitment and retention rates of Aboriginal and Torres Strait Islander student nurses and midwives in order to match the rates achieved for non-Indigenous students – this contributes to maintaining their funding base so their KPIs will be linked to student retention and completion.
- ***Employers***, particularly state and territory health departments, need to achieve employment targets for Aboriginal and Torres Strait Islander Australians across all job roles and levels, which contributes to greater cultural safety for Aboriginal and Torres Strait Islander clients and better health outcomes.

Therefore, it is important to do further work to identify whether and how educational institutions and employers can be partners and co-funders of the revised mentoring program, as its existence and success has significant benefits for them. Further, we anticipate that funding options within the Australian Government may be limited in the current fiscal climate, particularly as they may see this as a responsibility of state/territory health departments and possibly the ACCH Sector who will gain the workforce, as well as universities that have national accreditation standards to meet regarding recruitment and support of Aboriginal and Torres Strait Islander students.

Recommendation 12 of the 'Gettin em n keepin em' report identified the role of universities in workforce retention: "University Indigenous Student Support Centres to collaborate with schools of nursing to **identify personnel** with appropriate skills and knowledge **to mentor or tutor** Indigenous students of nursing" (p. xiii).[11] Therefore, universities could secure places for their students through co-funding the CATSINaM mentoring program.

***Recommendation 2: Program partners and co-funders***

*State and territory health departments and educational institutions should be formally approached by CATSINaM regarding their willingness to partner with CATSINaM in co-funding a mentoring program that supports Aboriginal and Torres Strait Islander graduate and/or student nurses and midwives.*

[11] Op cit.

## What is the core program concept?

CATSINaM would be wise to develop a formal mentoring program that has a clear project plan, structured process, formal training, formal agreements between all parties, and in built monitoring processes. This will:

- set a shared meaning of what does and does not constitute mentoring
- enable a formal matching process to occur
- facilitate a consistent approach while still responding to individual needs through mentoring resources that all parties use (e.g. mentoring handbook and a log book to document mentoring goals, activities and progress)
- provide a benchmark for a minimum mentoring period or number of mentoring sessions (that could be renewable)
- enable quality assurance for the mentoring process
- ensure accountability is built in.

This approach will also ensure that the program is set up well for planning and undertaking a formal evaluation, the outcomes of which could be published and contribute to the knowledge base on mentoring within the Aboriginal health workforce.

***Recommendation 3: Core elements of the mentoring program***

*CATSINaM should develop a structured mentoring program that requires potential Mentors to undertake training, applications be submitted for participation based on meeting agreed criteria (for both Mentors and Mentees), a matching process to occur, core mentoring resources/documents to be developed and used, and formal quality assurance and monitoring activities to be undertaken.*

***Recommendation 4: Formal evaluation***

*The program proposal should include funding for a formal evaluation to be conducted after 12-18 months from program launch, as well as after at least three years of operation.*

## What criteria should be used for participation?

In terms of Mentors, the criteria should focus on three main areas:

- personal qualities, e.g. non-judgemental, positive, constructive, encouraging, patient, an effective communicator, and aware of cultural safety and respect issues
- experience, e.g. a minimum of one to two years of experience since graduation

- availability, e.g. commit a minimum of one year supporting a minimum of one Mentee.

In terms of Mentees, the criteria should focus on:

- access to alternative support options
- need for personal development and professional support, not tutoring for students as this is provided through other avenues in universities
- exposure to racism in university or the workplace
- whether there is a risk of leaving study and/or the profession.

Regarding the last two points, the ideal situation is for mentoring to be a proactive program that is available whether or not students and graduates have had direct experiences of racism (in any of its dimensions) or are considering leaving. However, it is anticipated that demand will outstrip capacity so it will be important to prioritise people who are faced with difficult situations due to racism and/or are at risk of being lost from the profession in order to enhance retention in study and the workplace.

***Recommendation 5: Criteria for participation***

*Clear criteria should be established for Mentors that focus on personal qualities, experience and availability, while criteria for Mentees should focus on access to alternative options, need for personal development and professional support, and level of risk of leaving study or the workforce.*

## How should Mentors be supported?

An essential component of quality assurance is ensuring that Mentors feel competent and confident to undertake their role. Although initial training should set a strong foundation, Mentors need access to further training and support so they can reflect on and improve their mentoring practice. Individual Mentors can include this in their personal learning plans, so this can assist them in meeting their CPD requirements for maintaining registration. A requirement to attend at least one mentoring network event per year could be included in the contract that Mentors sign once they are accepted into the program.

***Recommendation 6: Mentor peer support***

*Mentor peer support should be a formal part of the program, with Mentors required to attend a minimum of one mentor networking event per year.*

## What flexibility should be built into the funding proposal?

Flexibility needs to be reflected in the funding proposal on the basis of two main factors:

- ***Career stage*** – a student stream and a graduate stream to the program is warranted, based on differences in needs as well as circumstances. The student stream requires engaging with universities, although if attached to a scholarship where there is a required period of service to the employer funding the scholarship, then engagement with employers is also required; this would be a three-way partnership between CATSINaM, the university/ies and the employer/s. The graduate stream requires engaging with employers, whether or not a formal cadetship program is in place.
- ***Number of places and geographical reach*** – different costed program options will be needed to reflect the needs and resources from co-funders and partners, and the availability and capacity of CATSINaM Members to be Mentors, as this will determine the program footprint in terms of program places and geographical reach.

Regardless of program stream or option, the funding proposal should have core elements such as: project management, mentoring training, implementation, monitoring and review processes, and evaluation. It should also be possible to identify where efficiencies can be gained by co-funders based on their collaboration with other geographical locations or co-funders.

***Recommendation 7: Flexibility in the funding proposal***

*The core program elements should be identified in the funding proposal and accompanied by different costed options to reflect: a student and a graduate program stream; examples of a local, jurisdictional and national program; and the capacity for resource efficiencies through collaborative work.*

## What timeframe should be proposed in the funding proposal?

If this is considered 'Phase 1' of the revised mentoring program, then a minimum of three years should be proposed. As students are a priority group, this will allow CATSINaM and its partners and co-funders to track the impact of mentoring in raising completion rates for universities that participate in the program and compare them to their previous completion rates.

It will also enable a mid-term evaluation to occur within 18 months of program launch. This will have a high focus program implementation (process or formative evaluation) as well as gain early information on impact and outcomes against the program objectives and goals (impact/outcome or summative evaluation). The mid-term evaluation outcomes will inform any refinement of the program and allow that to be implemented over the following 18 months. It can also be used as evidence to enable expansion of the program through other partners and co-funders.

An evaluation could then occur just prior to the three year point that will have a greater focus on achievements against the program objectives and goals. It can contribute to our knowledge base on mentoring within the Aboriginal health workforce, and also inform a 'Phase 2' of the program which may involve expansion to more people and/or jurisdictions, and extension into a new priority group, e.g. mid-career and later career nurses and midwives.

***Recommendation 8: Timeframe***

*The funding proposal should be described as 'Phase 1' and have an initial three year timeframe.*

# Appendix: Steering Committee Terms of Reference

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|---|---|
| **Lead responsibility** | CATSINaM Membership Engagement Officer (MEO) |
| **Reporting to** | CATSINaM CEO |
| **Review objectives** | **1:** To identify and document the current successes, challenges, enablers and barriers to providing a mentoring program to Aboriginal and Torres Strait Islander nurses and midwives at different stages of their professional life.<br>**2:** To create a viable proposal for a revised mentoring program to implement in 2014-2015 |
| **Responsibilities** | ▪ Provide advice on planning and implementing the review process<br>▪ Contribute information from their experience with the existing CATSINaM Mentoring Program<br>▪ Contribute information through consulting other Members about their experience with the CATSINaM Mentoring Program<br>▪ Review and provide feedback on documents produced through the review, i.e. review outcomes report and a revised mentoring program proposal |
| **Membership** | A five person review group will work with the CATSINaM MEO and CEO in undertaking the review. They will be:<br>▪ Two Members who have been Mentors<br>▪ Two Members who have been Mentees (one of whom needs to be a student)<br>▪ A Board representative |
| **Meetings** | Two face to face meetings: February and May 2014<br>Two teleconferences: March and April 2014 |
| **Deliverables** | A Mentoring Program Review Report with recommendations for the future<br>A viable proposal for a revised mentoring program |
| **Timeframe** | February – June 2014 |