

Allied Health ReConnect Project

Literature Review

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CONTENTS

| | |
|---|-----------|
| 1. Purpose | 4 |
| 2. Background | 4 |
| 3. Methodology | 5 |
| 4. Triggers for Re-entry Program Development | 5 |
| 5. Re-entry Programs in NSW | 7 |
| 6. Re-entry Participant Profile | 8 |
| 7. Structure Of Re-entry Models | 8 |
| 7.1 Format of re-entry programs | 8 |
| 7.2 Content of re-entry programs..... | 10 |
| 7.3 Length of re-entry programs | 11 |
| 7.4 Suggested audience for re-entry programs | 13 |
| 7.5 Re-entry classes..... | 14 |
| 8. Critical Success Factors for Re-entry Models | 16 |
| 8.1 Administrative considerations | 16 |
| 8.2 Support | 16 |
| 8.3 Planning for students' needs | 17 |
| 8.4 Assessment of participants..... | 18 |
| 8.5 Marketing..... | 20 |
| 8.6 Other..... | 20 |
| 9. Difficulties Experienced with Re-entry Programs | 21 |
| 9.1 Clinical placements..... | 21 |
| 9.2 Cost | 21 |
| 9.3 Access | 21 |
| 9.4 Depth of content | 22 |
| 9.5 Incentives for participants | 22 |
| 9.6 Rural issues..... | 22 |
| 9.7 On-line re-entry programs..... | 23 |
| 10. Re-entry Model Funding | 24 |
| 11. Barriers to Workforce Re-entry | 25 |
| 12. Evaluation of Re-entry Programs | 25 |
| 13. Transferability of Re-entry Models | 26 |
| 14. References | 27 |

1. PURPOSE

To provide a synopsis of the findings of recent literature on topics related to re-entry of out of practice professionals into the workforce.

2. BACKGROUND

The National Health Workforce Strategic Framework (2004) contains a vision, guiding principles and related strategies to direct health workforce policy decisions. Considering the predicted decreasing supply of health workers over the next 20 years, combined with an ageing population and the subsequent increase in demand for health services, a framework for maintaining an adequate supply of health workers is required. One suggested strategy in this framework is workforce re-entry.

The workforce profile of allied health professionals indicates a predominantly young and female workforce with attrition rates for some professions ranging between 4 - 11%. This suggests an available pool of qualified allied health professionals, who could be 'refreshed' and supported to return to the workforce through the provision of a re-entry program.

The NSW Health Workforce Action Plan (2005) identifies the need for a strategic approach to health workforce development, including a focus on recruitment and retention of the health workforce. In April 2006, NSW Health implemented the Allied Health ReConnect Project as a recruitment strategy to increase the supply of allied health professionals in disciplines experiencing workforce shortage in the NSW public health system. The initial phase of the project involved conducting a literature review of re-entry programs to identify the required components and critical success factors for workforce re-entry. This information could then be used to develop an allied health re-entry model framework that would be relevant across a range of allied health professions and would support the re-entry of individuals to the NSW public health system.

A review of the literature relating to re-entry programs that operated either in Australia or internationally revealed that most literature referred to nursing re-entry and limited information was available about allied health. A search for re-entry models outside of the health professions was not successful. In order to gain more specific information on allied health re-entry, selected re-entry models reported in grey literature have also been included in this review.

There are four operational allied health re-entry programs available to individuals in NSW, in the professions of speech pathology, nuclear medicine technology, radiography and radiation therapy. All programs are implemented by the professional associations with the exception of the radiation therapy 'Distance Education Return to Work Program', which is funded by the Australian Government and delivered through Monash University. Evaluation reports of these re-entry programs were not available for review.

Workforce re-entry strategies for nurses are also available in NSW. The College of Nursing offers refresher courses for registered nurses and midwives. In addition, NSW Health has implemented a workforce initiative termed 'Nursing Reconnect', which is a clinically focussed, supported employment re-entry plan that provides a mechanism for nurses to re-enter the NSW public health system.

3. METHODOLOGY

- Words and phrases used as key words in this review relate to “re-accreditation”, “re-activation”, “re-entry”, “re-certification”, “re-credentialing”, “re-training”, “re-admission”, “return(ing)”, “career break”, “refresher courses” and “return to practice”.
- Search period 1979 - 19 April 2006

4. TRIGGERS FOR RE-ENTRY PROGRAM DEVELOPMENT

It is widely reported in the literature that a primary reason for development of re-entry programs is to address a chronic workforce shortage (Griffiths & Czekanski, 2003, Williams, Brown, Crispin & Gibson, 2002).

Surveys of individuals currently inactive in their profession have determined their potential interest in a re-entry program. In the United States, Ehrmeyer, Hansen, & Stone (1979) found that of 176 inactive medical technologists, 78 expressed interest in a re-training program. Although there was not a shortage of technologists at that time, the program was developed to benefit individuals and society. Previous programs had found that re-trained technologists are valuable employees who remained working in their profession once they had undergone the retraining program.

A survey of 182 physical therapists who participated in a 2 week re-entry program in the United States was carried out by Rader & Clendenin (1991). The primary reason stated for attending the course was to refresh or update knowledge (75% of respondents). Reasons cited for needing to update knowledge included to enable re-entry to the workforce (61%), to reenergise in an existing job (19%), to prepare for a change in responsibility in job (10%) and to meet continuing education requirements for licensure (1%). Other reasons were to increase confidence and to overcome language difficulties.

Meyers (1993) reported that the development of a refresher course for occupational therapists in the United States occurred to address an increased demand for occupational therapists in health care, as well as to assist occupational therapists to update their knowledge and skills to remain effective practitioners, and increase their self-confidence. The program was targeted towards three groups:

- Re-entry to practice individuals;
- Individuals currently practicing who wished to change speciality; and
- Individuals currently practicing who wanted to refresh their knowledge.

Andre and Hall (1999) stated that the re-entry program offered by the University of South Australia for nurses re-entering the workforce was not developed in response to a nursing shortage, but to provide previously registered nurses with a choice of approaches to re-enter the workforce. The Nurses Act of South Australia requires registered nurses to demonstrate active practice in the last 5 years to maintain registration. In order to re-activate registration, previously registered nurses are required to undertake a recognised re-entry program.

White, Roberts and Brannan (2003) discussed the triggers for the development of an online re-entry program for out of practice nurses in the United States. They felt that cost and access issues made it impractical to run face-to-face refresher courses for

nurses in rural or geographically isolated areas. Nurses involved in the program identified travelling long distances to a campus-based course a barrier in returning to practice. They also emphasised the need for a flexible learning environment to cater for work and family obligations, emphasising the usefulness of an on-line or correspondence based re-entry program.

The National Association of Emergency Medical Services (EMS) Educators in the United States commissioned the National Association of EMS Educators Standards and Practices Committee (2004) to produce a position paper that discusses the necessity of recertification for EMS professionals. The paper highlighted the necessity for self-regulating professions to develop and maintain credible, useful standards to ensure the professional accountability of its members. The paper stated that it is necessary to periodically re-evaluate a professional's knowledge and skills to ensure they remain adequate and in line with current medical evidence. This was considered of particular importance for professions where techniques and equipment frequently change.

A review of grey literature found that the trigger for developing an occupational therapy re-entry program in Victoria was to facilitate workforce re-entry in rural areas. Rural areas experience a high staff turnover rate among casual workers and there are difficulties recruiting and retaining well-practiced staff. Workforce issues such as occupational therapy being a female dominated profession, overseas work opportunities, and a move to positions that provided better career outcomes such as project work or injury management were all cited as reasons individuals left the field. The report stated that an ageing profile of the population is leading to an increased demand for services from consumers and associated increases in workplace stress for workers resulting in high levels of attrition from the field (OT Australia Victoria, 2004).

Summary:

- Re-entry programs may be useful to address workforce shortage, and the predicted decrease in workforce supply over the coming decades.
- Studies indicate there is interest from out of practice professionals in re-entry programs.
- Refresher programs could be considered not just for out of practice individuals, but also for individuals currently working, to ensure a minimum level of skills and knowledge.
- Re-entry programs may also be useful to assist individuals currently in the workforce to change speciality, increase their confidence, refresh their knowledge or "re-energise" in their job.
- Re-entry programs may assist individuals to find employment after a significant period out of the workforce.
- Re-entry programs should consider delivery options to cater for individuals who would find a 'campus based' program difficult to access.

5. RE-ENTRY PROGRAMS IN NSW

In NSW, there are currently four allied health professions that require registration. These are pharmacy, physiotherapy, podiatry and psychology. At present, there are no formal re-entry programs in operation for these professions. It is at the discretion of each registration board to determine on a case-by-case basis whether an individual requires additional qualifications or training to become registered.

However, some other allied health professions do currently have re-entry programs available to individuals wishing to return to practice in NSW. Most programs are offered by the professional associations, and may be recommended to ensure eligibility for practising membership of the association. Re-entry programs exist in nuclear medicine, radiation therapy, radiography and speech pathology, and are described below.

Nuclear Medicine Technology: The Australian and New Zealand Society of Nuclear Medicine Accreditation Board developed a “Clinical Practice Program” for individuals who have practiced less than 576 hours in the last three years. The length of the program varies between 3 and 12 months, depending on the length of time out of the profession. The program involves placement in an approved department, where a number of core topic areas must be covered. The individual’s level of clinical competency is assessed. There is a small application fee to participate.

Radiography & Radiation Therapy: The Australian Institute of Radiography runs the ‘Resumption of Professional Practice’ program. For an individual who has not practiced between five to ten years, a competency based assessment must be undertaken before re-entering the workforce. Aspects of the re-entry program may be recommended. The re-entry program is mandatory for those who have not practiced for ten years. The program involves an initial assessment process to select candidates, a formal training program (which may involve a computer skills course, units from a University program and/or a fixed term employment, under conditions commensurate with a graduate practitioner undertaking a Professional Development Year (PDY), for a maximum of 12 months in an approved PDY Clinical Centre) and a competency-based assessment after a minimum of 6 months clinical practice. Fees apply for the re-entry program and the competency based assessment.

Radiation Therapy: A re-entry program tailored to radiation therapists is the ‘Distance Education Return to Work Program’ funded by the Australian Government and delivered through Monash University. Individuals must have been out of the workforce for a minimum of five years to apply. The program is comprised of a distance education component and a clinical component, which are completed concurrently. Candidates are remunerated during the program, and are employed for 3 months on completion of the program. Participants undergo a competency-based assessment after a minimum of 6 months full time equivalent clinical practice.

Speech Pathology: To be eligible for practising membership of the professional association, Speech Pathology Australia, individuals must undertake a re-entry program if they have practiced for less than 1000 hours over the previous five years. The purpose of the re-entry program is to update an applicant’s knowledge base, re-establish professional networks and act as a mechanism of support to the applicant when returning to the profession. It is generally accepted that eligibility for practising membership of Speech Pathology Australia is a requirement if someone is to be employed as a speech pathologist in Australia. The program involves a clinical component and completion of one or more of the following: accredited undergraduate

or postgraduate units, professional development courses or a self-study package. There is a fee for undertaking the program. Assessment is not currently based on clinical competencies.

6. RE-ENTRY PARTICIPANT PROFILE

The literature profiles individuals most likely to participate in re-entry programs in the health professions. Nursing and allied health literature in Australia and the United States report that between 90% and 94% of re-entry program participants are female, with the average age of a participant being in their early forties (Andre & Hall, 1999, Rader & Clendenin, 1991). The mean length of time since practicing varied from between 7.7 years (Andre & Hall, 1999) and 12.7 years (Baker & Copp, 1993).

The importance of considering family friendly work practices is highlighted by Andre and Hall (1999) who found that the majority of students in their nursing re-entry course in Australia had previously left the profession to attend to families, and 83% were continuing to care for children at the time they applied for the course.

The literature has also reported on the reasons individuals decide to re-enter their profession. Huggins (1990) reported that nurses in Missouri gave the following reasons:

- Single parent families needing an income;
- A change in marital status;
- The need for a second income;
- A failing economy;
- A return to employment after raising a family; and
- An inability to secure a position due to a lack of recent experience in the profession.

7. STRUCTURE OF RE-ENTRY MODELS

The re-entry programs discussed in the literature vary widely in terms of their format, content and length.

7.1 Format Of Re-entry Programs

There were a number of different formats for the structure of a re-entry program described in the literature. The most common models involved didactic content, usually presented at an institution such as a university or college, followed by a period of supervised clinical experience. Other elements included in some nursing programs were:

- Laboratory time to allow a “hands-on” application of the theoretical components (Huggins, 2005);
- Independent self-directed learning, using an online program (White, Roberts & Brannan, 2003); and
- Self-directed study modules and group discussion (Andre & Hall, 1999).

These methods were all considered effective to prepare individuals to re-enter their profession. A particular structure does not seem to influence the success of the program; rather flexibility is the key factor. Individuals will come to a re-entry program with differing amounts of knowledge and skills, different expectations of the program, different learning styles and differing needs for support. Continuous adaptability of

staff involved in the implementation and teaching of the program is a core requirement for success.

The programs discussed above involved a set structure, with some programs individualised to meet each participant's needs. In grey literature, the Health Professions Council in the United Kingdom allowed a flexible period of updating for allied health professionals, outlined in their report titled, "Returning to Practice" (Health Professions Council, 2006). The report stated each individual could choose the components of their program, making up a set amount of days. This decision was made following consultation with key stakeholders and the public between July and September 2005. A response to comments from the consultation, titled "Returning to practice: Your responses to the consultation, and our decisions" (Health Professions Council, 2005) proposed activities that could be included in a return to practise program including:

- Supervised practice;
- Formal study e.g. attendance at conferences or continuing professional development workshops; and
- Private study e.g. accessing online information, libraries and journals.

The "Return to Practice" report (Health Professions Council, 2006) confirmed these three methods of updating however stated that private study can make up no more than half the updating period. The document outlining responses to the consultation (Health Professions Council, 2005) indicated that concerns were expressed about whether private study alone could adequately prepare an individual to return to the workforce. Private study was considered useful in very specialised professions, where there may be limited options for formal study or supervised practice. Another advantage was its flexibility for those returners who must fit their re-entry requirements around other commitments such as caring for family members or around other employment.

The flexible structure proposed in the Health Professions Council model (2005) was viewed positively by many stakeholders however concerns were expressed that an individual would have difficulty structuring their program independently and may require mentoring or support in order to identify their learning needs. Some stakeholders also emphasised that private study in particular should be directed or structured by a supervisor. The final report (Health Professions Council, 2006) suggested that re-entrants contact their professional association for support on structuring the program.

In a survey of radiologic technologists in the United States, 82.9% of respondents who had stated they would consider taking a re-entry program before returning to the workforce believed that re-entry programs should encompass time spent at clinical sites (Baker & Copp, 1993).

The importance of a supervised clinical component was also highlighted in allied health grey literature. The United Kingdom Health Professions Council consultation document (2005) stated that comments suggested supervised practice should be an essential component of a re-entry program, however this was not mandated in the final report (Health Professions Council, 2006). Participant feedback within an evaluation report of an occupational therapy re-entry project in Victoria (OT Australia Victoria, 2004) stated that the majority of participants found the 10 hour clinical observational placement useful but some comments reflected that it was not sufficient in length.

Summary:

- Various formats for teaching knowledge and skills can all be effective.
- Flexibility is the key factor; Program structure must be flexible and staff involved in teaching the program must be adaptable.
- A supervised clinical component is required.
- Private study can be a useful component for highly specialised professions.
- Individualisation of the program for each participant is required.
- A mentor and/or individualised support should be available to each participant.

7.2 Content of Re-entry Programs

The content of a re-entry program for a specific allied health profession would vary considerably between disciplines, depending on the degree of change that has occurred in that profession, for example, advancements in technology, changes in what is considered best practice with assessment and intervention, and the introduction of new medications.

A review of both allied health and nursing literature suggests the consideration of the following areas when planning program content:

- A review of basic sciences e.g. anatomy, neurology and physiology (Meyers, 1993, Rader & Clendenin, 1991).
- A review of basic clinical skills (White, Roberts & Brannan, 2003, Williams, Brown, Crispin & Gibson, 2002).
- A review of content related to specific clinical areas, particularly those that have undergone the most recent and significant change in regards to procedures and instrumentation (White, Roberts & Brannan, 2003, Ehrmeyer, Hansen & Stone, 1979).
- Assessment of patient needs, planning individualised care and conducting treatment procedures (Griffiths & Czekanski, 2003, Meyers, 1993).
- An introduction to contemporary professional influences such as content on power structures, health care systems, politics, law, ethics and research, and how these have changed health care delivery (Andre & Hall, 1999, White, Roberts & Brannan, 2003).
- Andre & Hall (1999) also suggested focussing a number of sessions on job application issues such as preparing a curriculum vitae, writing an application letter and performing in an interview. This would be of particular importance if securing employment were not a part of the re-entry program.

Griffiths & Czekanski (2003) asked participants in their nursing re-entry program in the United States about their goals at the beginning of the program. Participants stated that they wanted to be able to provide safe patient care, regain skills, increase knowledge, re-develop self-confidence and develop competence with equipment and medications.

Participants learning styles and needs may differ widely, and must be addressed. Flexibility and adaptability with course content and presentation methods is therefore required. Griffiths & Czekanski (2003) suggested that for nurses this could be addressed by conducting an assessment of the participant's current knowledge base on the first day of the course. The prepared course content could then be modified to reflect the specific learning needs of the participants. Additional materials and readings could also be provided to participants, if required, particularly when requested content is beyond the scope of the course.

Griffiths & Czekanski (2003) found that the learning process of the re-entry course participants differed from that of undergraduate nursing students, leading to a recommendation that when content is covered, it should be closely followed by the opportunity to implement the skills taught.

When content is introduced, it should be related to an area that is likely to be familiar to the participant. E.g. Body systems was covered as an initial topic in a nursing re-entry course so that students could see that not everything had changed in the field. New technology or concepts should be discussed in the context of the previous technology/skill that has been replaced or enhanced (Andre & Hall, 1999).

Participants may require additional support in professions such as nursing and medical technology that require the understanding and use of mathematical concepts and computers, which were both highlighted as areas that students found confronting (Ehrmeyer, Hansen & Stone, 1979, Andre & Hall, 1999).

Ehrmeyer, Hansen, & Stone (1979) found that materials that are used to teach course content to undergraduate medical technology students are readily adaptable for re-entry programs, with supplementary materials needed for some of the newer and more complex topics.

Ehrmeyer, Hansen, & Stone (1979) stated that the course objectives used to guide course content in the re-entry program for medical technologists were derived from the entry-level competencies identified by the professional society. Andre & Hall (1999) reported that the clinical assessment in the re-entry program for nurses was based on the Australian Nurses Council Competencies for Registration, at the level of a beginning Registered Nurse.

Summary:

- Certain core knowledge and skill areas should be included in a re-entry program.
- Participants' learning styles must be considered when preparing and presenting content.
- Flexibility with the content covered is required, considering individual need.
- New information taught should be related to previously learned information.
- Comprehension of mathematical concepts and computer use may present difficulties for some participants.
- Course content should be based on entry-level professional competencies wherever possible.

7.3 Length of Re-entry Programs

The re-entry programs reviewed in the nursing literature ranged in length from between 144 hours (Griffiths & Czekanski, 2003) and approximately 480 hours, equivalent to 12 weeks (Andre & Hall, 1999). All nursing programs reviewed included both a theoretical and a clinical practice component. The ratio of time spent on teaching theory compared with direct clinical experience varied. The majority of programs invested at least the same or a greater amount of time on the clinical component than on the theoretical component (Griffiths & Czekanski, 2003, Huggins, 2005, White, Roberts & Brannan, 2003, Williams, Brown, Crispin & Gibson, 2002).

Most nursing programs, regardless of their length, reported positive program outcomes, evidenced by high ratings of satisfaction by participants and/or high rates of post program employment (Andre & Hall, 1999, Huggins, 2005, Williams, Brown, Crispin & Gibson, 2002). However the re-entry program discussed by Griffiths & Czekanski (2003), which was 144 hours in length, stated that there was some apprehension by course participants about how quickly the course material was covered. It was therefore recommended that future courses allow for adjustments in the course schedule to accommodate the group learning needs, and that the time frame be extended so that theoretical content could be better integrated into the practical role.

Andre & Hall (1999) stated that the intensive nature of a nursing program consisting of eight weeks theory and four weeks clinical placement did not suit everyone. They suggested that options should be available for students who wish to study at a slower pace or those who have difficulty accessing an institution-based program.

The re-entry programs discussed in the allied health literature were often shorter in length than the nursing programs. Rader & Clendenin (1991) discussed a 2 week physical therapy refresher course and although the length of the program was not specifically evaluated, 96% of the 177 surveyed individuals who had completed the course believed it was worthwhile. Meyers (1993) reported on a 2 week refresher course for occupational therapists and stated that participants felt the program length was appropriate. However, a limitation of the study was that individual outcomes from the program were not objectively measured. It was concluded that future programs must assure the competency of inactive therapists in order to ensure the efficacy of the program.

In grey literature, a pilot occupational therapy re-entry program, consisting of 2 days of theory and 10 hours of clinical observation, reported that some participants believed the program length was not sufficient. Comments from participants indicated that the program did not cover in detail all topics of interest, or the depth of knowledge needed, considering the amount of specialised information required to work as an occupational therapist, particularly if work was in a specialist area (OT Australia Victoria, 2003).

The United Kingdom's Health Professions Council report "Returning to Practice" (2006) stated that return to practice requirements for allied health professions are based on the time an individual has been out of practice:

- 0 - 2 years out of practice - no requirements.
- 2 - 5 years out of practice - 30 days of updating.
- 5 years or more out of practice - 60 days of updating.
(One day being equivalent to 7 hours).

The “Returning to Practice” (2006) report also stated that the above lengths of time are minimum requirements and that it is the responsibility of the individual to ensure they meet the Health Professions Council’s standards for safe and effective practice before returning to the workforce.

Summary:

- Allied health re-entry programs discussed in the literature are shorter in length than those discussed in nursing literature. In some programs, the length was not considered adequate to teach a sufficient amount of content. However length of programs did not influence program outcomes.
- Nursing literature suggested programs that contain both theoretical and clinical components, and are at least 144 hours in length, should be effective in re-entering nurses to the workforce.
- Nursing literature suggests that effective re-entry programs contain a clinical component that is of equal or greater length than the theoretical component.
- Any proposed length of time for a re-entry program should be considered a minimum, as some individuals may require greater theoretical or practical experience to become comfortable to return to their profession.
- Due to the variations in experience, knowledge and skills between individuals who are preparing to re-enter their profession, level of competency should be used to determine readiness for return to work, and not the length of the course.
- Options for individuals who do not suit an intensive, institution based re-entry program should be available.

7.4 Suggested Audience for Re-entry Programs

Of the three professional associations who currently offer allied health re-entry programs in NSW, all propose that an individual undertake a re-entry program if they have practised less than a specified number of hours over a certain period. The amount of hours and the time period specified varies between disciplines (Australian Institute of Radiography, Australian and New Zealand Society of Nuclear Medicine, Speech Pathology Australia).

Speech Pathology Australia, the professional association for speech pathologists require an individual to participate in the association’s re-entry program if they have worked less than 1000 hours during a five year period, else they are ineligible for practising membership of the professional association. The requirements of the re-entry program then depend on the length of time the individual has been out of the profession.

The re-entry program (termed “Clinical Practice Program”) implemented by the Australian and New Zealand Society of Nuclear Medicine recommend that nuclear medicine technologists who have worked less than 576 hours in the previous three years should undertake the program.

The United Kingdom’s Health Professions Council (2006) stated that a return to practice program is compulsory for those allied health professionals who have been out of the workforce for two years or more, before registration will be granted. The two year period was chosen so that people who take leave for a short period of time, particularly those on leave to start a family, are not affected by the re-entry requirements.

The Health Professions Council document, “Your responses to the consultation, and our decisions” (2005), asked for comments on whether an individual who had been out of the workforce for five years, should be required to undergo a re-entry program of the same length as somebody who had been out of the workforce for 10 years, 15 years or more. Many respondents who commented on this felt there should be a further requirement for those out of the workforce for greater than 5 years. Suggestions included complete retraining, an assessment by the professional body to ensure competency or that the employer should take responsibility for any extra training requirements. These recommendations were not taken up in the “Returners to Practice” (2006) final report.

The national association, Speech Pathology Australia state in their re-entry program that if an individual has been out of practice 15 years or longer, additional retraining requirements should be undertaken, such as the study of selected coursework through a university.

Summary:

- Allied health professional groups have suggested an individual needs to take part in a re-entry program if they have not practised in their profession for a specific amount of time. The times stipulated range from between 2 and 5 years.
- Some professional groups indicated additional requirements above a re-entry program e.g. completing university units, may be needed if an individual has been out of the workforce for longer than 15 years.

7.5 Re-entry Classes

The majority of re-entry programs cited in the literature were conducted at an institution such as a university, college or health care facility. As such, the theoretical component of the course was taught within a class situation. The literature highlighted the following advantages of having a small class size (Griffiths & Czekanski, 2003, Huggins, 2005, Ehrmeyer, Hansen & Stone, 1979):

- Promotes group cohesiveness;
- Encourages peer interaction;
- Builds trust;
- Allows closer interaction with faculty members;
- Manages the diversity in skill level of the participants;
- Enables individualised instruction when required; and
- Facilitates an open dialogue.

With nurses and medical technologists, a small class size increased the amount of individualised instruction, reduced participant anxiety, and allowed the utilisation of adult learning principles. It was recommended that class size be restricted to between 12 and 15 participants (Griffiths & Czekanski, 2003, Ehrmeyer, Hansen & Stone, 1979).

Although the literature showed a preference for a class format, White, Roberts & Brannan (2003) emphasised that cost and unpredictable class size made it impractical to run refresher courses for nurses in rural or geographically isolated areas. As such, an online re-entry program was developed.

Video-conferencing was considered as a tool to deliver a 2 day training course in a pilot occupational therapy re-entry program in rural Victoria, discussed in grey literature. However video-conferencing was abandoned after consultation indicated that participants felt it would limit the interactivity between participants and the facilitator, as well as reduce opportunities for networking and peer support. These factors were viewed to be critical in addressing issues around confidence, skills and knowledge (OT Australia Victoria, 2003).

Summary:

- Class formats are effective if class size is restricted to 15.
- Alternatives, such as an online course or correspondence course are required in rural or geographically isolated areas, as long as opportunities for peer and educator support exist.

8. CRITICAL SUCCESS FACTORS FOR RE-ENTRY MODELS

The literature highlighted a number of important considerations that are critical for re-entry program success. Of particular importance was the provision of support through mechanisms such as ensuring clear and frequent communication, using adult learning principles to teach content and establishing flexible and individualised programs. Further details on critical success factors are outlined below.

8.1 Administrative Considerations

The importance of project planning was emphasised in the nursing literature (Huggins, 2005, White, Roberts & Brannan, 2003, Griffiths & Czekanski, 2003). The following considerations were suggested:

- Ongoing communication with the participant should occur prior to the program to reduce anxiety, reassure the participant, assist with problem solving and answer any questions that have arisen. The participant should be given contact details upon enrolling for the course so that follow-up questions can be answered.
- Participants appreciated a welcome letter, a clear course outline and prompt posting of course materials, to enable preliminary reading to occur before the start of the course.
- For online re-entry programs, an orientation via a self-directed online tutorial was recommended before starting the course to familiarise participants with the computer system used.
- A re-entry program coordinator is essential to assist with recruiting, marketing, planning and implementing the course content, as well as supporting the participants.
- Flexibility of the course start date is required. For example, having preset dates so that participants are able to select a course that best coincides with when they wish to commence employment.
- Communication between course administrators and clinical placement facilities was highlighted as a critical factor for program success as well as a key area at risk of breakdown.

8.2 Support

Nursing literature reported that participants require ongoing support throughout the program (Huggins, 2005, White, Roberts & Brannan, 2003, Griffiths & Czekanski, 2003). Initially, support is required to assist a participant to decide whether they should take part in a re-entry program.

Constant reassurance and support is also required during the didactic and clinical placement experiences. It is daunting for an individual to return to a hospital environment that has changed significantly. A re-entry program is also likely to be demanding on time. Participants may not be used to studying. They may feel overwhelmed, particularly if there is a need to juggle jobs and families as well as the program. The critical period seems to be the first three weeks, after which time improved coping strategies are in place (Huggins, 2005).

To facilitate participant support, Huggins (2005) suggested encouraging intra-group peer interaction, including assigning a buddy to each course participant and suggesting participants exchange phone numbers.

In grey literature, OT Australia Victoria (2003) stated that participants valued the availability of support and contact with their professional association during the re-entry program.

The importance of preceptor support was also referred to in the nursing literature. Some programs ran a workshop to prepare preceptors for their supervisory experience. Huggins (2005) reported that a one-day 'Mentoring Workshop' provided information on the definition of mentoring, advantages for the mentor and mentee, as well as discussion around the attitudes, knowledge and skills required to be an effective mentor. In the re-entry program discussed by Griffiths & Czekanski (2003) preceptors received written guidelines on their role in supervising program participants. The guidelines included information on goals of the experience; expected outcomes for the course participants; overview of the content that was presented in the didactic element of the course and suggestions for practice during the clinical experience. It was suggested that the preceptors receive the guidelines before commencement of the placement.

The literature also made suggestions for the length of clinical experience a preceptor should have before undertaking supervision of a re-entry course participant. White, Roberts & Brannan (2003) suggested a minimum of two years postgraduate experience in their nursing refresher course. In grey literature, the policy and procedures manual outlining requirements for Speech Pathology Australia's re-entry program (2002) recommends the supervisor have a minimum of five years clinical experience, previous supervisory experience and be a current practising member. The Health Professions Council United Kingdom report (2006) stated clinical supervisors must have been in regulated practice for at least the previous three years and must not be subject to any fitness to practice proceedings.

Summary:

- Participants require support from the point they enquire about the re-entry program up until program completion.
- Support could be provided by the re-entry program coordinator, instructors, preceptors, peers or the professional association.
- Preceptors also require support. Support could be provided by running a mentoring workshop, or supplying preceptors with a mentoring package before the program commences.
- Recommended that preceptors should have at least two years post graduate experience before supporting re-entry program participants through clinical placements.

8.3 Planning for Students' Needs

Nursing and allied health literature described three main issues that need to be considered when re-entering individuals back into the workforce (Huggins, 2005, White, Roberts & Brannan, 2003, Griffiths & Czekanski, 2003, Meyers, 1993, Andre & Hall, 1999, Rader & Clendenin, 1991):

1. Confidence and self-esteem are likely to be low.
2. Learning needs and expectations may differ from undergraduate students.
3. Each participant will come to the course with a different level of skill, knowledge and need.

The following areas should be considered when planning a re-entry course:

- *Building confidence and self-esteem:* Re-entry program facilitators should provide a supportive learning environment, to reduce participant anxiety and increase self esteem and self-confidence. Support could involve clear and frequent communication, peer support and learning, and using adult learning principles when teaching. (Huggins, 2005, Meyers, 1993).
- *Trust and Open Communication:* Andre & Hall (1999), who evaluated nurses' experiences of a re-entry program, found that many of the students felt it significant that staff teaching the program were women with varied life experience. Trust and honesty between students and lecturers were important components. These concepts were discussed openly in class, along with responsibility around disclosure of information to others and maintaining confidentiality.
- *View of Learning:* Older students expectations of education may be traditional and as such, they may take a passive role in the learning process. They may have difficulty with the concepts of critique and reflection. Conversely, they are likely to have higher levels of motivation compared to undergraduate students and are more likely to quickly accept responsibility for their learning (Andre & Hall, 1999).
- *Adult Learning Principles:* Participants learning styles should be assessed. Teaching should incorporate adult learning principles. Utilisation of a variety of teaching techniques, such as formal classes with lecture and discussion, laboratory time, textbook readings, journal articles, web sites, videos and case studies has been suggested in the literature (Huggins, 2005, White, Roberts & Brannan, 2003).
- *Program Individualisation:* The course should be individualised for each participant, with a focus on his or her previous experience, learning needs and goals for future practice (White, Roberts & Brannan, 2003).
- *Program Flexibility:* If the re-entry program requires attendance at classes, these should be timetabled so that they do not interfere with obligations of parents with school age children. Clinical placements should be organised according to participant needs e.g. rural placements should be organised for those who reside in a rural area, or placements with flexible working hours should be organised for participants with children (Andre & Hall, 1999).

8.4 Assessment of Participants

The importance of assessing participant outcomes following completion of a re-entry program was widely discussed in allied health and nursing literature (Griffiths & Czekanski, 2003, Meyers, 1993, Ehrmeyer, Hansen, & Stone, 1979, Andre & Hall, 1999), as well as in grey literature (OT Australia Victoria, 2004).

In an occupational therapy refresher course, Meyers (1993) stated that although the majority of participants reported they increased their knowledge of practical information through the course, their degree of acquired knowledge and skills was not objectively assessed. This made it difficult to draw conclusions about the knowledge and skills the participants actually attained. The author stated that the topic of assessment should be approached cautiously with potential participants in

case feelings of low self confidence and anxiety about testing deter individuals from attending.

In literature that discussed measuring knowledge of re-entry course content taught didactically or via self-directed learning, the assessment involved pre and post testing, or a post test only. The minimally accepted standard was considered to be a score above 70%. Re-testing was allowed in some cases. Some re-entry courses did not allow entry into the clinical placement component of the program until a satisfactory rating was achieved on the theoretical testing (Griffiths & Czekanski, 2003, Ehrmeyer, Hansen & Stone, 1979).

Andre & Hall (1999) suggested assessing participants in a nursing re-entry program with small test items at regular intervals, so that early feedback on performance was available. Participants said they found it useful to gain a progressive view of their achievements and that the smaller test items reduced their anxiety, which helped to keep them focussed and on task. Frequent small testing also assisted staff to diagnose problems early on and implement any supportive strategies.

In courses that required a laboratory component, like that discussed by Ehrmeyer, Hansen & Stone (1979) for medical technologists, participants were observed during a laboratory session and marked according to whether they met the minimum competency defined by the instructor, based on the standards set for the undergraduate students.

Griffiths & Czekanski (2003) discussed clinical placement assessments for nursing re-entry program participants. It was recommended that meetings be held on a day-to-day basis between the preceptor and the participant, for feedback and evaluation purposes, with a final evaluation to occur at the end of the clinical placement. Competency was measured against each component of the clinical placement. Andre & Hall (1999) and OT Australia Victoria (2003) stated that competency should be measured against the entry-level competency based standards of a profession, if available.

Participant assessment in the refresher courses for registered nurses and midwives run by The College of Nursing in NSW includes drug calculations and testing of mastery of clinical skills in a simulated clinical environment (The Nursing College of NSW website).

The Health Professions Council in the United Kingdom (2006) does not require the clinical skills and knowledge of individuals undertaking the "Return to Practice" program to be assessed before granting registration. Instead, individuals must document information about their updating including the activities undertaken and the time spent on updating, to demonstrate they have completed the necessary requirements. This information must be counter-signed by a supervisor who is registered, and is then checked and processed by the Health Professions Council.

The Distance Education Return to Work Program for radiation therapists in NSW requires participants to submit a portfolio of professional development as part of their assessment, to assist to demonstrate their knowledge and competence. In addition, participants are required to undergo a competency-based assessment after a minimum of six months full time clinical experience (NSW Health Guidelines, 2006).

Summary:

- Assessment of participants' knowledge and skills should be a core component of a re-entry program, but should remain sensitive to the anxiety participants may feel towards testing.
- Assessment should be based on entry-level competencies of a profession, if available.
- Assessment should occur for didactic, laboratory and clinical components of a re-entry program.
- Developing a portfolio of professional development experiences could be considered as part of the assessment process.

8.5 Marketing

A number of methods for advertising reconnect programs are reported in the nursing literature (Huggins, 2005, Williams, Brown, Crispin & Gibson, 2002):

- Advertisements in local community newspapers;
- Feature articles in local community newspapers;
- Continuing education columns in professional association publications;
- Health system newsletters;
- Websites, including health system websites; and
- Letters to registration boards and universities advising of the program.

Evaluation of the Nurses Refresher Re-entry Supervised Practice Program implemented by the Victorian Government (2005) reported that the most effective way of recruiting participants for the program was through advertising (40%) followed by word of mouth (21%). Other methods such as through health organisations or websites were less effective.

In nursing literature, Williams, Brown, Crispin & Gibson (2002) warned against downplaying the complexities of the clinical area individuals are re-entering, in initial advertising and recruitment processes. While this may make a re-entry program more attractive and non-threatening, it may result in unrealistic expectations of participants. Subsequently, participants may be unprepared for the learning challenges that face them.

8.6 Other

In nursing literature, Huggins (2005) recommended a number of additional strategies to assist with re-entry program success, including:

- Emphasising to re-entry participants that the re-entry program is only the beginning of a life-long learning process, and stressing the importance of knowing where and how to access information in the future, to assist in realistically preparing participants for the workforce.
- Implementing incentives for clinical preceptors to participate in the re-entry program, such as providing a pay increase while they are mentoring.
- Facilitating employment opportunities for participants by providing them with health service recruitment contacts, as well as running activities on resume writing and interviewing.

9. DIFFICULTIES EXPERIENCED WITH RE-ENTRY PROGRAMS

A number of potential difficulties that may be experienced with re-entry programs were described in the literature. Rural issues need to be considered, as do issues relating to cost, access and content of programs. A description of these and other possible difficulties are explored below.

9.1 Clinical Placements

Clinical placements presented a number of challenges for re-entry program coordinators, preceptors and participants, which are discussed below:

- Mentors and/or clinical preceptors are considered critical to support participants through the re-entry process. However in an occupational therapy refresher course, Meyers (1993) stated that mentors were often difficult to identify or lacking in numbers.
- In grey literature, OT Australia Victoria (2003) reported that gaining public liability and professional indemnity insurance for observational, work-based placements for occupational therapists was difficult, as re-entry program participants were not considered to be 'students'.
- Difficulties may present if staff involved in re-entry program training are not experienced, particularly if they are assessing a participant's suitability for professional registration. Andre & Hall (1999) stated that preceptors in a nursing re-entry program need to be very skilled in clinical assessment and should be able to teach a broad range of content. Lecturers also need to be perceptive to student difficulties and know how to access additional resources for student support.
- In nursing literature, Williams, Brown, Crispin & Gibson (2002) reported that the needs of re-entry participants on clinical placement vary significantly from the needs of staff that have recent experience and are starting a new role with the service. Preceptors must be aware of these differences, well prepared for their role and have access to support.

9.2 Cost

Cost was a recurring factor reported in the literature as a barrier to developing and implementing a re-entry program. Baker & Copp (1993) surveyed radiation technologists who stated that cost would be a factor in deciding whether to pursue a re-entry program. Most respondents reported they would pay to participate however a small percentage stated that course costs should be met by the hospital or organisation promoting re-entry, and not by the participant.

The cost of a 180 hour nursing refresher program was reported by Huggins (2005) to be a significant limitation during the initial years of the program. The program was time intensive to develop, and when combined with hours invested in teaching, mentoring and program maintenance, the program was costly to implement. However costs for the program decreased once it was established.

9.3 Access

Re-entry programs that involve a traditional classroom model may restrict access to participants who live away from the training location. In a survey of radiation technologists by Baker & Copp (1993), many respondents listed travel distance as a major concern, suggesting a home study program should be considered.

Andre & Hall (1999) reported that a nursing re-entry program was scheduled during school hours to ensure access for women with school age children, and a shorter (3 month) course duration was implemented to increase access for those who had to travel or needed to gain employment quickly. Rural placements and non-standard shifts were also offered to assist with childcare needs. Students were also given a choice of clinical placement venues to increase access.

9.4 Depth of Content

Huggins (2005) reported that the content covered in a refresher course for nurses was quite focussed and might not have met the needs of those interested in speciality areas. This has significant implications for allied health professionals, considering the breadth and depth of knowledge needed for practising in a generalist area.

9.5 Incentives for Participants

Most of the programs reviewed in the literature did not ensure employment for participants on completion. Those that did, such as the nursing program discussed by Williams, Brown, Crispin & Gibson (2002) had excellent outcomes for staff retention, with all three staff remaining with the team 12 months following completion of the program.

Nurses involved in the NSW Health Nursing Reconnect initiative are recruited into a pre-existing vacancy on a full-time or part-time basis as part of the re-entry process. The appointment is dependent on a transparent recruitment process, which ensures that the reconnect nurse is not given any preferential treatment over nurses already employed in the health service. An individual's employment is subject to a probationary period of up to 13 weeks and performance management is commenced at the beginning of the employment (NSW Health, 2005). This initiative has had excellent retention results for nursing in NSW Health.

Being paid while re-entering is a strong incentive for individuals. Given significant nursing shortages, the NSW Nursing Reconnect initiative remunerates individuals who return to work through this strategy, from the first day of their training. The Department of Health provides Area Health Services with three weeks salary at 8th year for a Registered Nurse and 5th year for an Enrolled Nurse. The nurse receives an Award wage, depending on their years of experience as per the Public Health Service Nurses and Midwives Wage Rate Schedule.

9.6 Rural Issues

Services for Australian Rural and Remote Allied Health (SARRAH) published, 'A Study of Allied Health Professionals in Rural and Remote Australia' (2000) on their website. The study, involving over 1600 allied health professionals, outlined a number of issues that are significant to re-entry of individuals in rural areas.

- Only 18.3% of respondents had less than two years experience in their profession, indicating the majority of professionals would have a suitable amount of experience to be clinical preceptors for re-entry individuals.
- The retention rate of staff indicates a high turnover of professionals. Some 42% had been employed in their current workplace for less than two years. This has possible implications for acquiring preceptors, as individuals who are relatively new to their job may be less likely to take on supervisory responsibilities.
- Some 39.1% of respondents had never supervised a student, and 66.9% had never received training on student supervision. This may present difficulties in finding preceptors for clinical experiences in rural areas, as professionals may feel they lack the skills and knowledge in education and training to take on this role. It also highlights the importance of supporting the preceptor through the re-entry process.
- Only 50% of respondents were directly supervised by an allied health professional in the same discipline, either in the same or a different location. This may have implications for re-entry individuals who will require access to ongoing professional development and may need strong support from someone who has clinical experience in their field.
- Some 37% of respondents were sole practitioners. Rurally located individuals who complete a re-entry program and consider employment in a sole practitioner position post program may require additional support mechanisms if they continue to lack confidence.

While the number of nurses recruited as part of Nursing Reconnect in NSW is smaller in rural areas compared to metropolitan areas, Nursing Reconnect has reported no specific issues for rural recruitment with its strategy.

9.7 On-Line Re-entry Programs

White, Roberts & Brannan (2003) reported the following issues in running an on-line nursing re-entry program:

- Participants must be competent at using a computer and must have access to basic computer hardware and software to complete the program.
- Technical support was offered on-line; therefore participants must be able to use email to access this support.
- If participants are required to access on-line textbooks, publishers may be reluctant to allow this access.
- On-line testing requires the test to have a time limitation, to prevent the reliance on books and notes during the assessment.
- Participants will still require support, therefore course faculty must have skills in encouraging, motivating, interpreting and mentoring, as for face-to-face programs.

10. RE-ENTRY MODEL FUNDING

When funding re-entry courses was referred to in the literature, the majority of courses required re-entrants to pay a fee to participate (Andre & Hall, 1999, Ehrmeyer, Hansen & Stone, 1979, Huggins, 2005, Rader & Clendenin, 1991).

A survey of inactive radiation technologists by Baker & Copp (1993) asked respondents about re-entry course costs. The majority of respondents were happy to contribute to the cost of a re-entry course. However, 8.4% stated they would not be willing to pay for a course, and that hospitals or the institution running the re-entry course should be responsible for the cost.

The nursing refresher course discussed by Griffiths & Czekanski (2003) required potential candidates to be selected for employment at one of the hospitals involved in the program, to enrol. Qualified applicants were then paid a salary to participate and were required to commit to a 15 month period of employment after completing the course. The hospitals involved provided all funding for the course including coverage of costs incurred for implementing the academic part of the program, run by the nursing program at the Thomas Jefferson University College of Health Professionals.

The speech pathology re-entry program currently run by Speech Pathology Australia requires the participant to pay a re-entry membership fee to the association, and to fund all costs incurred when completing the program, such as professional development course costs. When an out of practice individual has successfully completed the program, they are then eligible for practising membership of the association. It is generally accepted that eligibility for practising membership of Speech Pathology Australia is a requirement if someone is to be employed as a speech pathologist in NSW or any other state or territory (Speech Pathology Australia, 2002).

The NSW Health Radiation Therapist Distance Education Return to Work Program was piloted in 2005 and is continuing in 2006. The program has Commonwealth funding for up to five successful candidates. Each candidate is funded to complete a 6 month FTE return to work program at the level of Medical Radiation Therapist Level 1 Year 1, which incorporates clinical practice at a Radiation Oncology Treatment Centre (ROTC) as well as completion of a self directed distance education program. Upon completion of the program, a further 3 months employment at a relevant ROTC is funded at the Level 2 Year 3 rate in the Award. A written review of the program is not currently available (NSW Department of Health, 2006).

The NSW Health Department and Area Health Services are jointly responsible for funding the NSW Health Nursing Reconnect initiative, where nurses who are not currently practising are employed into a pre-existing vacancy in the public health system. The NSW Health Department is financially responsible for coordinating the recruitment of individuals (e.g. maintaining the 1800 phone enquiry line). The salary of the Reconnect nurse is also paid for by the Department for the duration of their first three weeks employment (paid at 8th year Registered Nurse plus on costs), as well as a \$600 payment per nurse to the Area Health Service for preceptor support (Nursing & Midwifery Office, NSW Department of Health, 2007).

11. BARRIERS TO WORKFORCE RE-ENTRY

In a survey of nurses who had undertaken a re-entry program in Australia, Andre & Hall (1999) reported the following difficulties experienced by course participants when they tried to secure employment:

- Employers perceived re-entrants to have a lack of recent experience in acute care, most often citing 2 months experience in the last 2 years to be the minimum requirement for employment;
- Some employers were concerned about employing older nurses;
- Availability of child care, particularly if nurses were expected to work on an on-call roster system; and
- Fewer employment opportunities being available near the end of the financial year.

Baker & Copp (1993) also reported that some inactive radiologic technologists who had attempted to re-enter the workforce had experienced difficulty because employers were concerned about the length of time the individual had been out of practice.

In grey literature, OT Australia Victoria (2004) discussed a number of challenges to individuals returning to the workforce. These included:

- A lack of flexibility in workplaces e.g. limited opportunity for flexible working hours, part time employment and availability of job share;
- Availability of child care facilities when individuals returned to work; and
- Financial disincentives, after considering childcare fees, tax and travel costs.

12. EVALUATION OF RE-ENTRY PROGRAMS

The majority of literature reported on evaluation processes when discussing re-entry programs, most commonly using a questionnaire as the evaluation tool (Andre & Hall, 1999, Ehrmeyer, Hansen & Stone, 1979, Huggins, 2005, Rader & Clendenin, 1991, White, Roberts & Brannan, 2003) or a combination of a questionnaire and a focus group (Griffiths & Czekanski, 2003, Williams, Brown, Crispin & Gibson, 2002). Questionnaires that asked respondents to comment on their satisfaction with a component of the program usually used a Likert scale of between 4 and 7.

Nursing and allied health program evaluations commonly focussed on the following areas:

- The profile of participants;
- The reasons a re-entry program was undertaken;
- Participant satisfaction with the program, including aspects such as delivery, content, duration, quality of instruction, assessment, the degree of change in knowledge and skills and the degree of change in confidence;
- Preceptor satisfaction with the program, including their reflections on the course content and process, the impact of the program on their role and the benefits and drawbacks of the re-entry approach;
- Employer satisfaction with the process and outcomes of the program; and
- Employment outcomes post program, including whether employment had been secured, the length of time taken to find a position, the type of position gained, the re-entrant's satisfaction with employment and the re-entrant's preparedness for employment.

13. TRANSFERABILITY OF RE-ENTRY MODELS

Whether a re-entry program can be modified to suit another profession, or another area of speciality within the same profession, was not discussed in the literature. However the literature did describe a variety of re-entry models and emphasised the key criteria for their success. Incorporation of these criteria should enable development of a workable re-entry model framework for the allied health professions, which could then be individually tailored to each profession's needs.

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