Learning from Working Life:
Report of a Learning Set for Aboriginal managers in SA Health

Judith Dwyer and Kim O’Donnell | July 2013
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Acknowledgements

We are grateful to the anonymous participants in this project, who contributed their knowledge and insights to the work reported here, and to their supervisors who supported their engagement. We would also like to thank the staff in SA Health who contributed to the thinking behind this project, and supported the authors in its conduct, particularly April Lawrie-Smith and Heidi Silverston. Dr Angelita Martini assisted with analysis of survey data, and Danni Gray, Tiffany Carlin and Lisa Crowder assisted with organising and administration.

A word on language

Aboriginal English has some usages that we found helpful in the writing of this report. We have used ‘mainstream’ to refer to non-Aboriginal institutions, practices and settings. We use the term ‘Aboriginal’ because it is preferred by South Australian Aboriginal people to the more generic ‘Indigenous’. We recognise that many of the issues discussed in this report are likely to be experienced by Torres Strait Islander people.

Cover Artwork:

by Rama Kaltu-Kaltu Sampson

Painting Kuntjanu Tjukurpa courtesy of Better World Art

Rama Kaltu-Kaltu Sampson was born c. 1936 in Mt. Davis, Pipalyatjara, in the Anangu Pitjantjatjara Yankunytjatjara Lands. He is an accomplished painter and traditional ngangkari – doctor and spiritual healer. Rama painted at Ernabella for three years before coming to Adelaide. His strong knowledge of tjukurpa (dreaming) has earned him much respect and his work has been exhibited extensively across Australia. As an Anangu elder, Rama has a great wealth of traditional knowledge and skills. Rama’s country is Kuntjana, and he is custodian of the Wanampi Tjukurpa – the Rainbow Serpent Dreaming.
Summary

Introduction

This project was commissioned by the Department of Health and Ageing, and conducted by the Flinders University Department of Health Care Management. Its purpose was two-fold: first, to provide a professional development opportunity (participation in a learning set) for a group of middle-level managers and policy officers in the SA Health system. The second purpose was to gather information about their experiences in a methodical way, in order to improve understanding of the workplace challenges that this group of staff encounter – information that could potentially be applied in the Department’s efforts to improve the recruitment and retention of Aboriginal staff in the workforce.

Method

Seven Aboriginal participants who worked in management and policy roles (at about ASO7 level) were recruited, with the active support of their line managers. The learning set was conducted during the 2012 calendar year, facilitated by the authors of this report.

The learning set method is based on discussion of current real work problems or challenges, in an environment of mutual learning and psychological safety. The goal is for the participants to develop and apply analytical and problem-solving skills, as well as to deepen their insights into the pattern of problems that challenge them, and their responses. The effectiveness of the learning set was assessed using a pre- and post-intervention questionnaire and other information gathered progressively.

The second goal was to develop an analysis of the types of problems the participants find difficult, and the underlying factors in the workplace. Notes of the ‘stories’ the participants brought to learning set discussions were recorded at the time on a laptop, summarised and analysed. The participants were given opportunities to check the notes of their stories, and the developing analysis of the common themes emerging.

It is important to acknowledge that the data in this report arise from a focus on challenges and problems, not on the positive aspects of working in the Department. This focus is in accordance with usual practice in learning sets, on the basis that it is from challenging situations that professionals learn the most. However, this focus on problems can be seen as negative. We suggest that this kind of information is needed not only for individual learning, but also as the basis for organisational improvement. The alternative is to apply solutions without a clear understanding of what problem is being solved. Further, understanding the perspectives of Aboriginal staff is critical if the workforce goals of the Department are to be achieved.
Results: four major common themes

A total of 85 ‘themes’ (problems and their underlying factors) were identified in the data set; and they grouped clearly into four major categories, and five less common ones. The four major categories are:

1. The impact of cultural difference and discrimination

Given that participation in the learning set was defined by Aboriginality, it is not surprising that dealing with race and culture is the predominant theme. However, results from a learning set conducted among managers of Aboriginal Community Controlled Health Services were markedly different, with concerns about race and culture being the smallest of seven major groups (Dwyer et al, 2007:32), indicating that the work setting is an important contributor to these issues.

The strongest concern was about the workload and pressure arising from being the only or most senior Aboriginal person in the staff group, and/or being expected to deal with everything ‘Aboriginal’, including supporting non-Aboriginal managers to manage Aboriginal staff. Participants also reported a sense that the knowledge, experience and skills required to work well across cultures were not visible to, or not valued by, their co-workers and managers.

The challenge of intercultural work was also seen in practical matters like the need for participants to support Aboriginal people in the community with the sometimes challenging process of applying for entry-level jobs.

2. Problems with roles and responsibilities

The second major concern was about the design of roles and responsibilities in jobs that are designed to drive Aboriginal policy or service development initiatives. The need to use influence rather than authority to be able to complete essential tasks was raised often; along with a sense that the necessary leadership from those who did have authority was hard to mobilise. We note that this is a common concern among mid-level management and policy staff in any hierarchical organisation, but it was also clear that several participants occupied roles that had this problem built in to the job definition in very concrete ways.

3. Barriers in the organisation

There were two main components in this category. The first is that participants perceived that there were systemic barriers to their effectiveness that required leadership; but that leaders in the organisation sometimes could not see the importance of their attending to particular aspects of initiatives or projects. The second component in this category was the cost of restructuring. Participants were concerned about loss of momentum, staff turnover and changes of direction arising from the frequent restructuring in the health system.

4. The challenges of managing staff

In common with all management learning sets, the challenge of managing staff emerged as an important category in the problems participants encounter. Participants discuss some long-term problems in managing staff performance and working with difficult colleagues, as well as success in getting to a ‘win win’ outcome.
Results: the learning set worked for participants’ professional development

The real test of whether the participants benefited from the program is whether they are more effective in their work, but it is too early to assess this outcome.

Participants completed a purpose-designed questionnaire (Leggat et al 2011) that measures self-efficacy and empowerment, and perceptions of the conditions for work effectiveness. This group is too small for any tests of statistical significance on the results, and they are presented as descriptive only. There was a modest improvement on all measures, except job satisfaction which was unchanged.

Participants also completed some qualitative assessments, which indicated that the main value of the learning set for their professional competence was seen in improved insight into their own habits of response to situations and ways of working; and better understanding of ways to strategise and problem-solve. Participants also valued the sense of learning from other people’s problems – learning that others experience the same doubts and frustrations, and that there are ‘always solutions’. These comments are consistent with the quantitative results for empowerment and self-efficacy.

Findings and conclusions

This project indicates some potential areas of focus as part of SA Health’s efforts to enhance the workforce participation, retention and career progression of Aboriginal staff, and their contribution to the work of SA Health.

Strategies to address these matters must be developed in the context of commitment to the equity in health and access to health care for Aboriginal people; and recognition of the continuing influence of discrimination and prejudice. Discussion of these matters is very sensitive and difficult, as it is in the wider community. We have not yet arrived at a mutually agreed understanding of the unique place of Aboriginal people in Australia, and this lack of resolution affects those working in the health system. Lack of familiarity combined with reluctance to ‘put a foot wrong’ can mean that some staff avoid engagement with Aboriginal issues and Aboriginal staff. For others, prejudice against Aboriginal people is a strong barrier to working effectively with them.

Successful strategies in support of intercultural understanding, respectful behaviours and the achievement of equity in Aboriginal health and health care will involve action at all levels of the health system. The commitment of the leadership of the Department to these goals needs to be visible and concrete, and will require sustained attention.

Based on our analysis of the data we gathered, and on the experience of engaging in discussions about the participants’ problems at work, we suggest several areas of potential action that could make a difference, for consideration within the Department.
SUGGESTED ACTION 1:
We suggest that the Department conduct a small-scale trial of a program to support and guide mainstream managers of Aboriginal staff. The elements should include access to expert advice or coaching, and a development program to enhance their capacity and skills, with a view to broader implementation of interventions that show evidence of effectiveness. This intervention should be based on initial consultation with mainstream managers of Aboriginal staff about their challenges and concerns.

SUGGESTED ACTION 2:
We suggest that leadership in the Department consider the development of clear guidance to staff regarding the goal of equity in Aboriginal health, and its compatibility with the important principle of equal treatment in a public system, in order to address concerns that Aboriginal people are being afforded ‘special treatment’.

SUGGESTED ACTION 3:
We suggest that all Aboriginal staff at mid-level senior positions in SA Health have access to a program for their continuing professional development based on individual consultation, and potential inclusion of learning sets, coaching and other forms of professional development. Support for further study should be included in the options.

SUGGESTED ACTION 4:
We suggest that the Department consider ways in which the problem of mismatch of responsibility and authority in the conduct of Aboriginal health initiatives can be addressed; with a view to improving job design for staff charged with these roles.

SUGGESTED ACTION 5:
We suggest that all managers of staff be offered guidance in dealing with the impact of the burden of grief and loss carried by Aboriginal health staff on the staff themselves and their immediate work colleagues.

The data on which our findings and suggestions above are based is qualitative and is drawn from the experiences and challenges faced by a small number of participants. It is ‘first person’ data, not tested against the perceptions of colleagues in the workplace. However, we have used a reliable technique to identify the recurring themes in the problem ‘stories’ we collected; and the participants have endorsed our interpretations of their material. We are confident that the issues on which we have focussed are real concerns; and suggest that they offer insights that could be applied to the Department’s efforts to improve Aboriginal health care and to increase its Aboriginal workforce.
Introduction

Background

The Flinders University Department of Health Care Management was commissioned by SA Health (Workforce Division) to conduct this project. Learning from Working Life had two main aims, first to address (at least in part) the need for professional development for Aboriginal staff working in policy and/or management roles in SA Health. The second aim was to contribute to knowledge about the challenges the participants confront in the workplace by analysing the workplace problems they discussed.

Ms April Lawrie-Smith, Executive Director, Aboriginal Health, had identified a concern for Aboriginal health staff being appointed into policy and management roles often without the needed support, training and development. This lack of preparation for management or policy roles also happens in the health workforce generally, but the relative scarcity of Aboriginal staff in the workforce means it is more likely, and may happen sooner, for Aboriginal staff. Aboriginal staff may also face particular difficulties in their own efforts to address their skill and knowledge needs, including feeling isolated within mainstream units or branches, and difficulties in acknowledging and negotiating their development needs within the workplace because of mutual sensitivity about their status and/or discriminatory behaviour.

The project also contributes to meeting the obligations of the Department of Health Care Management to conduct a project of potential benefit to SA Health, arising from a larger contract. A small amount of funding was provided to cover the direct consumable costs of running the program, and to enable Ms Kim O’Donnell, an experienced Aboriginal facilitator, to work with Professor Judith Dwyer and develop knowledge and skills in learning set method.

The method: Action learning and learning sets

This project had a professional development goal and a research goal.

Professional development

An opportunity was publicised within SA Health for up to 8 Aboriginal staff who were in positions of substantial policy or management responsibility, but not at the most senior level – ASO7 level was used as a guide in the selection process. Approval and support from applicants’ line managers was a condition of acceptance. Officers of SA Health took responsibility for inviting and selecting participants. The facilitators took responsibility for all arrangements for set meetings and for the conduct of the learning and research aspects of the project. Regular contact was maintained with the Departmental officers.

The learning set method is based on discussion of current real work problems or challenges, in an environment of mutual learning and psychological safety. The goal is for the participants to develop and apply analytical and problem-solving skills, as well as to deepen their insights into the pattern of problems that challenge them, and their responses. At each meeting, each person outlined a current unsolved problem in their work. After discussion among set participants, the facilitator asked the person with the problem to sum up their action plan (‘What are you going to do?’); and at the subsequent meeting each member was asked to report back on what they had done and what the results were. Six one-day set meetings were conducted during 2012, facilitated by the authors.

Learning set method is based on action learning theory and focuses on analysis of the current real problems confronting the participants (Pedler 2008, McGill and Beaty 2001). Analysis and reflection are followed by participants taking action in the work setting, and reporting back at a subsequent meeting.

We also arranged and offered a pathway for postgraduate academic credit (equivalent to one topic or subject) for participants who completed the program and undertook a written assessment task.
Research component: understanding the challenges facing staff

The second goal was to develop an analysis of the types of problems the participants find difficult, the characteristics of the workplace that enable or impede their effectiveness, and the types of skills and knowledge that would assist them. Notes of the ‘stories’ the participants brought to learning set discussions were recorded at the time on a laptop, summarised and analysed. The stories document the kinds of problems staff struggle with, the contributing factors, the strategies they use to address the problems, and the enabling factors that support or assist their endeavours. This approach was based on a previous study conducted with senior Aboriginal health care managers in Queensland (Dwyer et al 2007).

Ethical approval was given by the Flinders University Social and Behavioural Research Ethics Committee. Participants were informed about the research component of the program in the initial call for applications, and the nature of the research and the safeguards for participants were discussed in the first and subsequent meetings. It was made clear that participation in the learning set was not dependent on consenting to participate in the research. However, all participants chose to consent.

After each set, each participant’s ‘story’ notes were returned to them for checking. And at each meeting except the first, the developing data set was presented to the participants for verification of the facilitators’ interpretation. Because of the sensitivity of the information in the stories, and to protect confidentiality, it was made clear from the beginning that no summaries of problems would be reported. Rather, thematic analysis was conducted, based on each story summary. The researchers analysed the stories to identify the nature of the problem, the contributing factors and the enabling factors or strategies that the participants intended to use to address the problem. This collection of themes was then analysed to identify the common and recurring elements, as well as the range of problems the participants encounter in the SA Health workplace.

It is important to acknowledge that the data in this report arises from a focus on challenges and problems, not on the positive aspects of working in the Department. This focus is in accordance with usual practice in learning sets, on the basis that it is from challenging situations that professionals learn the most. However, this focus on problems can be seen as negative. We suggest that this kind of information is needed not only for individual learning, but also as the basis for organisational improvement. The alternative is to apply solutions without a clear understanding of what problem is being solved. It should also be acknowledged that some readers may find it confronting to consider the perspectives of Aboriginal staff in isolation from the perspectives of others in their workgroups. We suggest that the documented lack of trust across the cultural divide (Reconciliation Australia, 2013:1) that (at least in part) underlies such a response is precisely part of the problem; and that understanding the perspectives of Aboriginal staff is critical if the workforce goals of the Department are to be achieved.

Evaluation

The goal of professional development in this context is to enable the participants to improve their effectiveness. A questionnaire, measuring self-efficacy and empowerment, developed at La Trobe University by Leggat and colleagues (2011) for use with learning set members, was administered to participants at both the beginning and the end of the project. While the number of participants was too small to enable statistical analysis of the validity of any observed changes, the results can be seen to give some indication of impact (or lack of it) of the program. Process evaluation was also conducted, using short questionnaires distributed to participants and completed at the end of each workshop.
Results: Major challenges for Aboriginal staff

Participation

Six meetings were held during 2012. A total of 7 people were accepted as participants and attended at least one meeting of the learning set. There were two withdrawals after commencement: one person (employed on temporary funding) left the Department after one meeting; and one person was promoted to a very busy senior position after two meetings, and did not participate further. The problem stories brought by those participants are included in the data analysis. However, for the purposes of calculating participation rates, they have been excluded. The average attendance of the 5 continuing participants was 77% (23 attendances of a potential total of 30).

Primary problem in each ‘story’

The stories were categorised according to main problem the person confronted. The pattern of the main problems is summarised in Table 1.

Table 1: Primary problems

<table>
<thead>
<tr>
<th>Primary problem</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce</td>
<td>5</td>
</tr>
<tr>
<td>Organisational barriers</td>
<td>5</td>
</tr>
<tr>
<td>Managing staff</td>
<td>4</td>
</tr>
<tr>
<td>Culture and Race</td>
<td>3</td>
</tr>
<tr>
<td>Managing self/career</td>
<td>3</td>
</tr>
<tr>
<td>Burden of illness, grief and loss</td>
<td>3</td>
</tr>
<tr>
<td>Partnerships/external relationships</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>26</strong></td>
</tr>
</tbody>
</table>

This pattern of problems has much in common with similar analyses of other learning sets (see Dwyer, Shannon and Godwin 2007:18-21). The main difference for Aboriginal sets arises from the need for Aboriginal people to deal with problems of culture and race.

Major areas of challenge

Classification by primary problem area gives some important information, but the stories reveal richer information about the context and the factors at work. Because of the strict confidentiality that is essential for learning set discussions, we have analysed the major common themes that recur in the stories, rather than presenting any summaries of stories.

There are four major areas of challenge that confronted this group of staff, and five other important areas. The groups of themes arising from the stories are listed in Table 2, and explained below.

Table 2: Major common themes

<table>
<thead>
<tr>
<th>Theme area</th>
<th>Number of occurrences</th>
<th>Number of individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race and culture</td>
<td>21</td>
<td>5</td>
</tr>
<tr>
<td>Roles and responsibilities</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td>Organisational barriers</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Managing staff</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Aboriginal Workforce</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Managing self/career</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Burden of illness, grief and loss</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>External relationships/partnerships</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Funding/financial resources</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>85</strong></td>
<td></td>
</tr>
</tbody>
</table>
1. The impact of cultural difference and discrimination

Given that participation in the learning set was defined by Aboriginality, it is not surprising that dealing with race and culture is the predominant theme. However, results from a learning set conducted among managers of Aboriginal Community Controlled Health Services were markedly different, with concerns about race and culture being the smallest of seven major groups (Dwyer et al, 2007:32), indicating that the work setting is an important contributor to these issues.

The strongest concern was about the workload and pressure arising from being the only or most senior Aboriginal person in the staff group, and/or being expected to deal with everything ‘Aboriginal’, including supporting non-Aboriginal managers to manage Aboriginal staff.

Aboriginal managers also find themselves taking on a kind of ‘interpreting’ role, interpreting Aboriginal social norms, behavioural expectations etc to non-Aboriginal staff, and vice versa. This role requires knowledge and skill to perform effectively, and can require significant personal strength and energy. Participants reported a sense that the knowledge, experience and skills required to work well across cultures were not visible to, or not valued by, their co-workers and managers. They also spoke about discriminatory behaviours among staff in general, and their experience of being judged on the basis of their Aboriginality, rather than as individuals.

2. Problems with roles and responsibilities

The second major concern was about the design of roles and responsibilities in jobs that are created in order to drive Aboriginal policy or service development initiatives. The need to use influence as an engagement strategy rather than authority to be able to complete essential tasks was raised often: along with a sense that the necessary leadership from those who did have authority was hard to mobilise. We note that this is a common concern among mid-level management and policy staff in any hierarchical organisation, but it was also clear that several participants occupied roles that had this problem built in to the job definition in very concrete ways (for example, a role that was required to produce reports using data to which the occupant did not have access in spite of repeated requests).

3. Barriers in the organisation

There were two main components in this category. The first is that participants perceived that there were systemic barriers to their effectiveness that required leadership; but that leaders in the organisation sometimes could not see the importance of their attending to particular aspects of initiatives or projects. The second component in this category was the cost of restructuring. Participants encountered problems that were exacerbated by the loss of momentum, staff turnover and changes of direction that inevitably arise from the frequent restructuring in the health system.

4. The challenges of managing staff

In common with all management learning sets, the challenge of managing staff emerged as an important category in the problems participants encounter. The most frequent issue was managing poor performance, which is always challenging, and even more so in the public service environment.
5. Workforce
There were two main workforce issues. The first arises from the current transition to registration for Aboriginal Health Workers who undertake clinical roles, with existing staff being reluctant to take on the transition; and the resultant reduction in availability of a skilled experienced workforce in this area. The second was concern about the barriers to recruitment for Aboriginal people, particularly those who might undertake non-professional entry-level jobs, arising from reluctance to work in mainstream settings and anxiety about selection processes.

6. Managing self and career
Participants discussed the challenge of priority-setting among competing priorities, of managing heavy workloads, and of facing promotional opportunities with uncertain faith in the fairness of the process. These are common concerns for managers at all levels.

7. The burden of illness, grief and loss
During the year, more than one of the participants experienced bereavement in their immediate families, and took on important responsibilities in mourning ceremonies and the grieving process. Participants discussed the burden of multiple early deaths in families and in their workplaces, and the sense of often not getting enough time to recover from one loss before having to confront another. The second element of this category was the impact of complex health problems, and of poor social and economic conditions on the design and effectiveness of health promotion programs for the Aboriginal community.

8. Partnerships/external relationships
Working with external partners requires greater flexibility in timelines and working styles than normally applies within the public sector; and meeting the needs of multiple stakeholders was experienced as a significant challenge.

9. Funding and resources
There was a small group of themes about lack of security for roles that rely on short-term funding; and the challenge of tight spending deadlines.
Evaluation: what difference did the learning set make for participants?

‘Learning is measured by the results of action’ (Revans 2011:10)

The real test of whether the participants benefited from the program is whether they are more effective in their work, but it is too early (and in any case difficult) to assess this outcome directly. We used two methods of evaluating the impact of the learning set for participants, and one method of evaluating the process. They are explained and the results are presented below.

Pre- and post- measures of efficacy and empowerment

Participants completed a questionnaire developed for the purpose of evaluating the impact of learning sets on health care managers (Leggat et al 2011), based on a range of validated measures of self-efficacy and empowerment, as well as perceptions of the conditions for work effectiveness, job satisfaction, internal motivation, job involvement and access to information. Participants were asked to complete a 5-point Likert scale in response to statements. Results for the five participants who completed both pre- and post-program questionnaires were analysed, and the pre-test questionnaires for the two who withdrew were discarded.

This group is too small for any tests of statistical significance on the results, and they are presented as descriptive only. There was a modest improvement on all measures, except job satisfaction which was unchanged, as summarised in Table 3 below.

Table 3 Pre- and post- LS comparison on measures of efficacy and other job characteristics

<table>
<thead>
<tr>
<th>Item (scale 1-5 unless specified)</th>
<th>Pre-test average</th>
<th>Post-test average</th>
<th>Percent change</th>
<th>Examples of statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-efficacy (scale 1-4)</td>
<td>3.16</td>
<td>3.34</td>
<td>6%</td>
<td>It is easy for me to stick to my aims and accomplish my goals</td>
</tr>
<tr>
<td>Conditions for effectiveness</td>
<td>3.49</td>
<td>3.9</td>
<td>12%</td>
<td>Are there rewards for effective management?</td>
</tr>
<tr>
<td>Empowerment</td>
<td>4.17</td>
<td>4.3</td>
<td>3%</td>
<td>The work I do is meaningful to me I have mastered the necessary skills</td>
</tr>
<tr>
<td>Job Satisfaction</td>
<td>4.5</td>
<td>4.5</td>
<td>0%</td>
<td>In general, I like working here</td>
</tr>
<tr>
<td>Internal motivation</td>
<td>4</td>
<td>4.2</td>
<td>5%</td>
<td>My opinion of myself goes up when I do my job well</td>
</tr>
<tr>
<td>Job Involvement</td>
<td>2.6</td>
<td>3.4</td>
<td>30%</td>
<td>I live, breathe and eat my job</td>
</tr>
<tr>
<td>Access to Information</td>
<td>3.8</td>
<td>3.9</td>
<td>3.5%</td>
<td>I understand top management’s vision of my organisation</td>
</tr>
</tbody>
</table>

These improvements are modest, and no claims are made for their significance.
Learning Results

In the post-program questionnaire, participants were invited to make comments on three key things that had changed about their work life as a result of their participation in the learning set. Responses (from 4 participants) focus on increased confidence, a sense of being valued, not being ‘alone’, ability to think through resolutions, and willingness to ‘ask more questions if required’. These responses are consistent with greater empowerment and self-efficacy.

Using a more informal method participants were asked to respond to 2 questions using post-it notes. The questions and responses are detailed in Table 4. These responses are also consistent with an enhanced sense of empowerment and self-efficacy.

Table 4: learning about self and others

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>What have you learned about your approach or style at work?</td>
<td>I don’t like wasting time and am focused on the job</td>
</tr>
<tr>
<td></td>
<td>To think about responses not react</td>
</tr>
<tr>
<td></td>
<td>To engage with others, and to make sure I have support</td>
</tr>
<tr>
<td></td>
<td>My style is isolating, I deal with issues by myself but don’t need to</td>
</tr>
<tr>
<td></td>
<td>To identify and strategise solutions, and be more confident</td>
</tr>
<tr>
<td>What have you learned about or from other peoples’ problems?</td>
<td>Problems are universal, solutions are there and we have influence</td>
</tr>
<tr>
<td></td>
<td>People have so many different ways – positive and negative</td>
</tr>
<tr>
<td></td>
<td>That I’m not alone</td>
</tr>
<tr>
<td></td>
<td>Advantage in problem-solving many common issues</td>
</tr>
</tbody>
</table>

While three members of the learning set expressed interest in the academic credit option, at the time of writing, none of the participants have taken this option up. However, this strategy has been successful in another context (Dwyer et al 2007), when the sponsoring organisation subsequently partnered with a University to provide a specialist stream within a health care management course.

Process evaluation

Participants were asked to complete ‘5 minute evaluation’ questionnaires at the completion of each learning set meeting. Five sets were collected, due to an oversight at one workshop. The questionnaires asked the participants to respond to standard statements about the workshop’s process and substance on a Likert scale from 1 to 5. Ratings for all workshops were collated and total average scores are shown in Figure 1.

All participants valued the learning sets highly, with all but one element scoring an average of over 90%. These results indicate high levels of satisfaction with the program, but do not of themselves confirm learning outcomes. Longer term follow-up with the participants would give an indication of their more considered assessment.
Figure 1: Overall ratings of workshop process

The group is working well together
I understand the overall purpose & Agenda
The session was well organised & informed
The material was well structured
The discussion was good
The facilitators managed the session well
I understand how to do the problem solving
It was interesting to work with other people's problems
I have a plan for addressing the issue I raised
I feel OK about the confidentiality arrangements
I'm motivated by the insights and support I get here
The workshop as a whole was helpful to me

Overall

Rating

Excellent - 5
Poor - 1
Facilitators’ Reflections

It always takes time for groups to ‘form’ – that is, for members to establish themselves in the group, for the expectations of group behaviour to clarify and for comfort and trust to develop. This group went through that process in the usual way. During the first 2-3 meetings most participants began by sharing problems they have no immediate control or influence over (again, this is a common issue for learning sets). For this group as for others, the impact of focusing on concerns outside one’s control tended to reinforce a sense of being stuck, raising a sense of despair about the potential for change in the situation of Aboriginal people generally and in the health workforce. However, gradually participants became used to the process and comfortable with the way facilitators redirected the focus back to situations they could influence and change. Humour was often used by individuals as a strategy to cope with stressful situations in their workplace and to lift the mood when discussions lingered too long in the areas they couldn’t influence.

In this group, Judith was the only non-Aboriginal person. Kim observed early in the process that when Judith acknowledged and said she valued the stories people shared, the group relaxed and opened up a little bit more. When Judith shared her experience of being a grandmother and passed a picture of her grandson around, the mood (or willingness to engage deeper) seemed to have shifted.

Kim facilitated meeting 5 as Judith was on leave. The group seemed to be more relaxed, and spoke less formally, using language and forms of expression that are common and understood by Aboriginal people. There was much conversation about the impact of persistent grief and loss on the health and wellbeing of individuals and their families and the struggle to manage this within the workplace. The group resolved to continue chipping away at the big picture however challenging things may become. The mood shifted from a sense of despair to hope that the lives of Aboriginal people are improving, although there is still a long way to go.

It was agreed that Kim would facilitate meeting 6 without Judith, to gauge whether participants were more comfortable to talk about problems they may not necessarily raise with Judith present. The focus was on effective leadership and appreciation of work as a place to take one’s mind off grief and loss. Participants seemed happier, content in their own decisions and were looking forward to having a restful break over the summer holiday period.

The facilitators came to the view that there are benefits in having experienced Aboriginal facilitators, and in having facilitators with deep knowledge of working in the public sector. While we aimed to promote the sharing of knowledge, we also understand that Aboriginal people may need their own space to share stories and experiences with each other without outside interpretation or judgement. Non-Aboriginal people may also need time and space to examine the challenges of intercultural work, and of addressing systemic racism and its profound impact in the lives of Aboriginal people (Gallagher et al 2009; Taylor, 2010; Dwyer, Kelly et al 2011). Feedback from participants on our reflections indicates that they agree.
Findings: implications for the workplace, for Aboriginal staff and for future staff development activities

This project indicates some potential areas of focus as part of SA Health’s efforts to enhance the workforce participation, retention and career progression of Aboriginal staff, and their contribution to the work of SA Health. The participants in this project were committed to working in SA Health, to the Department’s goals and to their roles. However, they also discussed several barriers against their work being more effective; and had a sense of working in an environment in which discrimination and bias persist among staff, with negative consequences for Aboriginal people and the organisation.

Strategies to address these matters must be developed in the context of commitment to the overarching goal of equity in health and access to health care for Aboriginal people; and recognition of the continuing influence of discrimination and prejudice. Discussion of these matters is very sensitive and difficult, as it is in the wider community. We have not yet arrived at a mutually agreed understanding of the unique place of Aboriginal people in Australia, and this lack of resolution affects those working in the health system. Lack of familiarity combined with reluctance to ‘put a foot wrong’ can mean that some staff avoid engagement with Aboriginal issues and Aboriginal staff. For others, prejudice against Aboriginal people is a strong barrier to working effectively with them. And at a higher level, the policies, practices and culture of the health system incorporate some features that build in bias or discrimination that is not consciously intended, but is a result of the way the system operates. For example, the rationing of assistance with travel for country patients may impact more deeply on Aboriginal people as a group than other country South Australians, because of a unique combination of factors (Dwyer et al 2011). Similarly, exclusion (intended or not) from informal networks among the work team may disadvantage Aboriginal staff members.

The term ‘racism’ is very sensitive, partly because it is used to cover such a wide range of phenomena, from the deep tendency to recognise one’s own ‘kith and kin’ that seems to occur in all racial groups at one end, to the enactment of hate crimes and genocide at the other. However, the concept of systemic racism (Feagin 2006), is a useful one in the effort to provide a workplace that is fair and respectful for all groups, and a health service that is equitable in access and quality of care for patients.

Successful strategies in support of intercultural understanding, respectful behaviours and the achievement of equity in Aboriginal health and health care will involve action at all levels of the health system. The commitment of the leadership of the Department to these goals needs to be visible and concrete, and will continue to require sustained attention.

Based on our analysis of the data we gathered, and on the experience of engaging in discussions about the participants’ problems at work, we suggest several areas of potential action that could make a difference, for consideration within the Department.

1. Effective supervision and coaching

Mainstream managers with responsibility for Aboriginal staff are confronted, possibly for the first time in their working lives, with the challenge of working inter-culturally. This can put them in a position of anxiety about ‘putting a foot wrong’ and/or bring their prejudices to the fore. These approaches lead to two different kinds of errors: avoidance or ‘bending over backwards’ (as a learning set member put it) on the one hand; and lack of support or failure to recognise contributions, skills, expertise and ambitions on the other.

SUGGESTED ACTION 1:

We suggest that the Department conduct a small-scale trial of a program to support and guide mainstream managers of Aboriginal staff. The elements should include access to expert advice or coaching, and a development program to enhance their capacity and skills, with a view to broader implementation of interventions that show evidence of effectiveness. The trial should be based on initial consultation with mainstream managers of Aboriginal staff about their challenges and concerns.
2. Respect and engagement

The South Australian health system is supported in its work for Aboriginal health, and to increase its Aboriginal workforce, by legislation, by the Cultural Respect Framework, by the SA Health Plan and a specific Aboriginal Health Implementation Plan. However, it seems that this ‘high policy’ has not been effectively translated into operational policies, procedures and programs that could provide guidance for staff in their efforts to improve Aboriginal health and health care (Dwyer et al 2011).

The implementation of cultural safety training (however titled) is the most visible effort in this regard. However, the evidence indicates that such training as practiced has not been sufficiently effective to make a real difference (Westwood and Westwood 2010, Downing and Kowal 2011). We note that practitioners have responded to this evidence with improvements in the relevance and acceptability of the training. However, it is also clear that training alone will not be sufficient to change entrenched patterns of behaviour and thinking.

This is not primarily a matter of ‘being nice’. Anxiety and prejudice can influence mainstream managers’ judgement about the impact of policy decisions and operating assumptions, their capacity to recognise the need for managerial discretion to enable innovative methods to be tried, and at its most basic, their willingness to engage in work for Aboriginal health.

We note that South Australia’s strong legislative base for supporting respect and engagement was recognised in a national review (Howse 2011:7):

‘A standout exception is South Australia, with the South Australian Public Health Act 2011 mentioning the needs of Aboriginal and Torres Strait Islander people. Reference is made to their particular needs in the objects (Part 2(4)(f)): to provide for or support policies, strategies, programs and campaigns designed to improve the public health of communities and special or vulnerable groups (especially Aboriginal people and Torres Strait Islanders) within communities.’

SUGGESTED ACTION 2:

We suggest that leadership in the Department consider the development of clear guidance to staff regarding the goal of equity, and its compatibility with the important principle of equal treatment, in order to address concerns that Aboriginal people are afforded ‘special treatment’.

3. Tailored staff development

This project was a trial of one approach to developing the professional effectiveness of Aboriginal staff in mid-level senior positions, with a focus on their strategic, managerial and analytical abilities. On the basis of the results reported above, it is clear that the method is appropriate for and valued by the participants. However, access to other types of programs is important for enhancing disciplinary and technical knowledge and skills. The number of staff at this level in the system is sufficiently small that individual attention to their development is feasible.

SUGGESTED ACTION 3:

We suggest that all Aboriginal staff at mid-level senior positions in SA Health have access to a program for their continuing professional development based on individual consultation, and potential inclusion of learning sets, coaching and other forms of professional development. Support for further study should be included in the options.

4. Job and project design

There are two main issues. The first is the use of stand-alone policy or project officer roles with responsibility for the implementation of Aboriginal health initiatives which need to be embedded in normal operations. This method is also used for mainstream initiatives, and such roles can be the best or only way to provide coordinating or support services to an operational area while it initiates and implements change. However, in Aboriginal health, there was a sense of this approach sometimes resulting in a lack of engagement by the operational area. Leadership and engagement by the relevant senior manager is essential in these circumstances, in order to avoid setting the Aboriginal officer up to fail.
The second issue is the ‘responsibility trap’ for senior Aboriginal staff – that is, the risk that their workload escalates, and their focus dissipates, because of demands on their time that arise from their being the senior Aboriginal officer available, rather than from their specific role responsibilities. Sitting on selection committees, contributing to a broad range of planning and coordination meetings, and offering advice to the line managers of Aboriginal staff were the common examples. Attention to improving the capacity of mainstream managers to recognise and manage this issue may have an impact on this problem, and has been addressed in Suggested Action 1 above.

**SUGGESTED ACTION 4:**

We suggest that the Department consider ways in which the problem of mismatch of responsibility and authority in the conduct of Aboriginal health initiatives can be addressed; with a view to improving both practical senior management support and job design for staff charged with these roles.

5. Dealing with grief and loss

It is a confronting comment on the state of Aboriginal health that coping with the grief and loss from early deaths of family and community members continues to be a significant problem for Aboriginal people, including those in the health workforce. The primary goal must be to improve the health and life expectancy of Aboriginal people; but the burden on Aboriginal staff in the health system also calls for recognition. The experience of multiple deaths of people close to us is mercifully rare in the general community, and it is hard for us to understand the impact of many early deaths among those close to us. Aboriginal colleagues in the workplace are likely to experience this compounded grief and loss, and it is to be expected that it will have an impact in the workplace.

This is not primarily a question of leave; and in any case, normal leave provisions are now flexible enough to enable most circumstances to be managed. This is a matter that requires understanding and empathy, as any bereavement does. The impact of the excessive burden carried by Aboriginal staff is real; and there is an inevitable impact in the workplace (Gleadle, Freeman, Duraisingam et al 2010; Roche, Tovell, Weetra et al 2010).

**SUGGESTED ACTION 5:**

We suggest that all managers of staff be offered guidance in dealing with the impact of the burden of grief and loss carried by Aboriginal health staff on the staff themselves and their immediate work colleagues.

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**Conclusion**

The data on which our findings and suggestions above are based is qualitative and is drawn from the experiences and challenges faced by a small number of participants. It is ‘first person’ data, not tested against the perceptions of colleagues in the workplace. However, we have used a reliable technique to identify the recurring themes in the 26 problem ‘stories’ we collected; and the participants have endorsed our conclusions. We are confident that the issues on which we have focussed are real concerns; and suggest that they offer insights that could be applied to the Department’s efforts to improve Aboriginal health care and to increase its Aboriginal workforce.

We offer these suggestions for the Department’s consideration. We would be delighted to contribute to any processes that might be set up to consider how best to respond, and would suggest that such a process would be necessary as the concerns and the suggested solutions in this report are likely to be challenging. SUGGESTED ACTION 1 above could provide an important foundation for a constructive response.
References


