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ABORIGINAL HEALTH WORKERS: 
ROLE, RECOGNITION, RACISM AND HORIZONTAL VIOLENCE IN 
THE WORKPLACE

by

Josephine Winsor-Dahlstrom

A thesis submitted in partial fulfillment of the requirements for the degree 
of

Bachelor of Indigenous Health Studies (Honours)

Faculty of Health Sciences

The University of Sydney

2000

Supervisor's Signature ..............................................................
STATEMENT OF ORIGINALITY

I certify that I am the sole author of this thesis and that the substance contained herein has not already been submitted for any degree and is not being currently submitted for any other degrees.

I certify that to the best of my knowledge that any help received in preparing this thesis, and all sources used, have been acknowledged in this thesis.

Josephine Winsor-Dahlstrom
Acknowledgment

The completion of this thesis would not have been possible without the tremendous support of the Aboriginal people who participated in the study. Despite their busy lifestyle, they made themselves available for the interviews, telephone calls and e-mail messages. The information provided from them was invaluable and their support and encouragement was overwhelming. I would particularly like to thank the Aboriginal women of my community for making suggestions and providing positive criticism to make this all happen.

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Last, but not least, I would like to say a special thanks to my husband, Peter, for his breathtaking support, love and encouragement, particularly over the past few months. I would never be able to repay him for all that he and our son have sacrificed to help me through this personal journey and special time in my life. Thank you Peter.

Thanks a million, everyone.
Abstract

The aim of this project is to explore the role of the Aboriginal Health Worker, their recognition as a legitimate profession and the current racism most will face in the current New South Wales Health System. The position of the Aboriginal Health Worker was introduced to improve the consultation process with Aboriginal people about their health. It was also introduced to address their specific cultural needs around health. Anecdotal reports from the field by various Aboriginal Health Workers show that these objectives have, in large, not been met. A preliminary review into the literature was conducted which includes important discussions and studies into the history and development of the Aboriginal Health Worker role. This review is not placed in a single chapter, but is strategically placed throughout the thesis to demonstrate the impact of this development and history upon the different issues of role, recognition, racism and horizontal violence.

This project uses a qualitative approach using a descriptive study design. A sample of five selected participants of who were all ex-Aboriginal Health Workers joined the research project. The qualitative method of theme extraction was employed for data analysis which led to the emergence of themes which were grouped and compared to each other. The findings were contrasted with relevant literature in the field to fully understand the phenomenon under study and explore why objectives regarding Aboriginal Health Workers continue not to be met, despite Health Service Management rhetoric. The five ex-Aboriginals Health Workers were interviewed, in-depth, to provide information on the recognition, role and racism difficulties they faced at work. They were selected from five different Area Health Services so that the sample remains relatively heterogeneous. This ensures a record of experiences from as wide a variety of work environments as possible in the sample. The interviews reveal a deep sense of shame and hurt experienced by the Aboriginal Health Workers caused by both their communities and their employers. The paper presents the story of the despair experienced by those interviewed and shows examples of promised recommendations to facilitate the future recognition and contribution of the Aboriginal Health Worker. Limitations of the methodology and implications for further study are also discussed.
## CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Chapter Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Forward</strong></td>
<td>1-12</td>
</tr>
<tr>
<td>1</td>
<td>Introduction</td>
<td>13</td>
</tr>
<tr>
<td>1.1</td>
<td><em>The importance of this research</em></td>
<td>13</td>
</tr>
<tr>
<td>1.2</td>
<td><em>The research problem</em></td>
<td>21</td>
</tr>
<tr>
<td>1.3</td>
<td><em>Questions I will be asking</em></td>
<td>21</td>
</tr>
<tr>
<td>1.4</td>
<td><em>My personal experience</em></td>
<td>15</td>
</tr>
<tr>
<td>1.5</td>
<td><em>The purpose of this research</em></td>
<td>23</td>
</tr>
<tr>
<td>1.6</td>
<td><em>Thesis Outline</em></td>
<td>24</td>
</tr>
<tr>
<td>2</td>
<td><strong>Methodology</strong></td>
<td>25</td>
</tr>
<tr>
<td>2.1</td>
<td><em>Introduction</em></td>
<td>26</td>
</tr>
<tr>
<td>2.2</td>
<td><em>Limitations</em></td>
<td>27</td>
</tr>
<tr>
<td>2.3</td>
<td><em>Methodologies</em></td>
<td>28</td>
</tr>
<tr>
<td>2.4</td>
<td><em>The Interviews</em></td>
<td>29</td>
</tr>
<tr>
<td>2.5</td>
<td><em>Ethical Considerations</em></td>
<td>32</td>
</tr>
<tr>
<td>2.6</td>
<td><em>Data Analysis</em></td>
<td>33</td>
</tr>
<tr>
<td>2.7</td>
<td><em>Outcomes</em></td>
<td>35</td>
</tr>
<tr>
<td>3</td>
<td><strong>Role of the Aboriginal Health Worker</strong></td>
<td>37</td>
</tr>
<tr>
<td>3.1</td>
<td><em>Introduction</em></td>
<td>37</td>
</tr>
<tr>
<td>3.2</td>
<td><em>Issues impacting on Aboriginal Health Worker Role</em></td>
<td>42</td>
</tr>
<tr>
<td>3.2.1</td>
<td><em>Management versus Culture</em></td>
<td>42</td>
</tr>
<tr>
<td>3.2.2</td>
<td><em>Management and Health Policy</em></td>
<td>47</td>
</tr>
<tr>
<td>4</td>
<td><strong>The Recognition (&amp;Status) of Aboriginal Health Workers</strong></td>
<td>52</td>
</tr>
<tr>
<td>5</td>
<td><strong>Racism (&amp; Discrimination) against Aboriginal Health Workers</strong></td>
<td>57</td>
</tr>
<tr>
<td>5.1</td>
<td><em>Racism</em></td>
<td>69</td>
</tr>
<tr>
<td>5.2</td>
<td><em>Discrimination</em></td>
<td>73</td>
</tr>
<tr>
<td>6</td>
<td><strong>Horizontal Violence</strong></td>
<td>76</td>
</tr>
<tr>
<td>6.1</td>
<td><em>Workplace Bullying</em></td>
<td>76</td>
</tr>
<tr>
<td>6.2</td>
<td><em>Definitions</em></td>
<td>77</td>
</tr>
<tr>
<td>6.3</td>
<td><em>Horizontal Violence &amp; subordination of Aboriginal Health Workers</em></td>
<td>77</td>
</tr>
<tr>
<td>6.4</td>
<td><em>Gender Issues in Horizontal Violence</em></td>
<td>93</td>
</tr>
<tr>
<td>7</td>
<td><strong>Conclusions of the research</strong></td>
<td>94</td>
</tr>
<tr>
<td></td>
<td><strong>References</strong></td>
<td>99</td>
</tr>
</tbody>
</table>
FORWARD

Australian Aboriginals were the first human societies to occupy the continent of Australia. Separate Aboriginal language groups were responsible themselves, through their ancestors, for shaping their own spirituality, history, lore and law and for adapting a lifestyle that was harmonious with the land and environment. It was this connection Aboriginal people had with the land that ensured they enjoyed a good quality of spiritual, mental, physical, emotional and environmental well being. (Berndt & Berndt 1978, Elder 1988, Reid & Trompf 1991, Evans 1999) As Elder puts it:

"The Aborigines knew, loved and respected their land. It was their total raison d'être. It was their source of spirituality and strength." (1998: p11)

Elder's comment highlights the fact that Aboriginal life was totally intertwined with the land and environment. Both largely determined how Aboriginal society constructed their laws, education, leisure and health. Particularly with health, this attachment to the land resulted in a symbiotic relationship that encouraged an holistic system of healing through an extensive knowledge of local fauna/flaura and environmentally-determined medical practices ((Saggers & Gray 1991). However, this pristine lifestyle that Aboriginal Australian's upheld for thousands of generations began to end in 1788 ((Berndt & Berndt 1978, Elder 1988).

With the invasion of the Europeans and their deceitful falsehoods of Terra Nullius, the lifestyle and health of Aboriginal people changed forever. (Elder 1998) The events that followed European invasion resulted in traumatic and horrific experiences for Australian Aboriginals. The dispossession of Aboriginal land by European people forced Aboriginal people off traditional.
hunting grounds. This caused the destruction of traditional medicine required for existing and combating introduced disease such as smallpox, measles, and diphtheria. The results of massacres, genocide and dispossession of traditional land as well as the forced separation of Aboriginal people from their traditional food supply and the breakdown of the kinship system devastated Aboriginal health. To survive the impact of European invasion, Aboriginal people knew they would either die in the attempt to defend the land and the life that was known, or they had to accept and adapt to the drastic alterations in their lifestyle, which has continued through to the present time.

The maintenance of the good health and well being of Aboriginal groups was the responsibility of the traditional and complex integrated system of services. This system was built around clan caring and sharing. The healing of one individual did not just involve that person it entailed the whole extended family being involved in complex and detailed healing rituals. In regard to Aboriginal health, Elkin states that:

“As long as Aboriginal people have walked this land there have been people, who have looked after the health of their countrymen.” (Elkin, p12 1977)

Grootjans & Spiers identify these Aboriginal Health Workers (“...people who ... looked after the health of their countrymen.”) in the following way:

“Elkin, an anthropologist who has worked with Aboriginal people over many years call them ‘men of high degree’” (Grootjans & Spiers p21 1977)

Like so many early male anthropologists, these authors forgot that there were also ‘women
of high degree’. who are not represented in their male-dominated academic discourse. Their existence is simply excluded from any earlier analysis and study.

Like so many early male anthropologists, these authors ignored the idea of ‘women of high degree’ who are not represented in their male-dominated academic discourse. Their existence is simply excluded from any earlier analysis and study.

For Aboriginal women, traditionally food gathering demanded elaborate knowledge of the ecology, of plants and trees and roots, their properties as food and as medicine. They were described as guardians of the fire, as the inventor of medicine, woven vessels and the holder of the secret knowledge. Woman knew how to transform the raw materials and dead animals into nurturing products. Her skills must have been as manifold as those of men and certainly as essential. Her knowledge was perhaps greater or at least as great as the males. In the development of ritual and rites, of music, dance and song, women played as great a part in these roles as the men did. Aboriginal women were the equal of the men and, in many medical circumstances and practices, far superior.

Another misconception by non-Aboriginal society is that Aboriginal society was homogeneous, — there was not, at any time—before colonisation, one body of law universal throughout Australia, thus variations of spirituality, law and lifestyle occurred from one region to another. (Broome 1982, Evans 1999) There are differences between the many Aboriginal and Torres Strait Islander cultures but there are also some general similarities in traditional ways of thinking and being.
There were 500-600 different Aboriginal nations in Australia before 1788. All these nations had their own language, their own land area, their own spiritual beliefs, their own oral histories (Dreaming), their own laws, regulations, ceremonies and rites. (Monticone 1999) This gives rise to the need to consider the appropriateness of culturally based health services that are tailored to the specific needs of each local Aboriginal community. Thus, if the Aboriginal Health Worker is not primarily from the community they are to work in, there is a need to accustom themselves to that community’s cultural ideology and ways of healing (Grootjans & Spiers, 1997).

Australian Aboriginal culture was hunting and gathering and involved stones, bark, bone, fibre, wood and skins. This was all but destroyed by well-meaning missionaries. Elder states:

"...of well-meaning church groups with theological rigidity and missionary zeal using the laws to try and win converts, of sadists who beat and punished their young charges, of religious people who blindly refused to believe the stories they were told by the Aboriginals, and, more than anything else, of a deep racism which, by the definition of the 1948 Convention on the Prevention and Punishment of the Crime of Genocide, was unambiguously genocidal." (1998, p218)

The Aboriginal population has always been treated as ‘outcasts’ in our own country with very little support by the non-Aboriginal society of Australia. (Elder 1998)

In the 20th Century, the health status of Aboriginals is the poorest status of any identifiable sub-population in Australia. (Saggers & Gray 1991) Substantial social and economic disadvantage,
a history of cultural dislocation and undervaluing, a history of political oppression and an experience of substantial discrimination has resulted in extremely poor health for Aboriginals. (Saggers & Gray 1991) The importances of these reasons do vary according to the different circumstances of given Aboriginal communities throughout Australia. For example, remote communities have not seen the same improvements to their physical environment as have other Australians and this is reflected in their particular health problems. (Reid & Trompf 1991)

Many of these types of communities have, however, maintained social and cultural integrities which Aboriginals living in urban communities have not and therefore experience other health problems relating to their adverse social environment.

Bartlett, in her article ‘Aboriginal Health’ describes the phenomenon of dysfunctional individuals, families and communities as the ‘grief-anger-despair cycle’ that has developed since colonialism. The destructive cycle continues with lack of family and community cohesiveness leading to poor nutrition, substance abuse, violence, and suicide. This cycle further deteriorates the poor health status of Aboriginal people. Bartlett also cites the importance of enhancing the skills and capacities of Aboriginal and Torres Strait Islander Health Workers as crucial in enhancing the health status of Aboriginal and Torres Strait Islander Communities (Bartlett, 1998: 26).

The inequalities in Aboriginal health are highlighted by the number of diseases which commonly occur at the different stages in an Aboriginal’s life and occur much more commonly in Aboriginals than in non-Aboriginals. These include diabetes mellitus, circulatory system
disorders, respiratory disorders, ear disease, eye disease and specific communicable disorders. (Saggers & Gray 1991)

With such disparities in the health of Aboriginal Australians, it has become increasingly clear that steps must be taken to improve the health of Aboriginal people. These inequalities were recognised by the House of Representatives' Standing Committee on Aboriginal Affairs in the first major inquiry undertaken into Aboriginal health in 1979 (HRSCAA, 1979). Along with the unsatisfactory environmental conditions in which Aboriginals live, the inquiry attributed the lower health status to the low socio-economic status "and to the failure of health authorities to give sufficient attention to the special health needs of Aboriginals and to take proper account to their social and cultural beliefs and practices." (p iii)

Since this report, many unsuccessful attempts have been made to implement initiatives aimed at achieving these aims. Eleven years later, a primary thrust came from the National Aboriginal Health Strategy (NAHS), an initiative which the Commonwealth, State and Territory Ministers responsible for Health and Aboriginal Affairs agreed to process for implementation in 1990. When the health of Aboriginals is considered, similar themes emerge. The conclusions of the working party, which developed the NAHS, are consistent with the priorities identified by the Royal Commission into Aboriginal Deaths in Custody (1990).

It has been found that often decisions are made about the health of Aboriginal people without any consultation and without specific cultural needs being considered (Trengena & Abbott 1995). This

“While Government policies attempt to address Indigenous health issues, to date all incentives have provided no significant improvement in the health of Australia’s Indigenous People. While self-management is endorsed, the Indigenous voice, when proposing appropriate solutions to Indigenous problems is frequently ignored or given lip-service” (AEJNE, vol. 3, no. 2, p1)

As well as seeking opportunities for Aboriginal empowerment at the policy-making level, the NAHS is ‘supposedly’ committed to involvement of Aboriginals and Torres Strait Islanders in determining their own health at the program level. Training and current national ‘competency based’ training for the registration and recognition, nationally of Aboriginal Health Workers were believed to be steps in the right direction—although this is yet to happen. This important issue of lack of consultation and community input into health department policy and plans on the ground is further explored in the interviews and continues to be one of the major problems facing Indigenous health in Australia.

Among other policies and plans, changing the health system to focus on the needs of different groups in the population rather than the historical provision of services is one of the most effective ways to ensure that health gains are equally spread across the population. One such example was to employ Aboriginal people into mainstream health services to deal with specific
Aboriginal issues, eg. Cross-cultural training, looking after 'our own', etc (Tregenza & Abbot 1995). This type of strategy not only assists in bettering Aboriginal health, but also strengthens the Aboriginal culture and endorses self-management and self determination with an Aboriginal voice.

It is through this initiative to employ Aboriginal people into mainstream health services and all the previously mentioned structural difficulties that the Aboriginal Health Worker role was devised and tentatively implemented in the early seventies. Although recommendations from previous reports and studies (Flick, 1997, the New South Wales Task Force on Aboriginal Health in 1990 wrote The Last Report and Tregenza & Abbot 1995) regarding the employment of Aboriginal people into mainstream services has been followed, the specific positions of Aboriginal Health Workers, eg. Aboriginal Liaison Officers (in hospitals), Aboriginal Health Education Officers (in Area Health Services) and others, do not have a generic job description and therefore can not unite as one voice in raising concerns of the positions, lack of consultation, recognition of the qualifications and roles or show common discriminatory attitudes and behaviours of other health professionals and management in the health system.

Aboriginal Health Workers continue to work under extreme duress in these conditions, requiring multiple skills to manage the continuous, day-to-day stress that these issues force upon the Worker. This lack of a unified voice means that, although many anecdotal stories of racism and lack of recognition can be collected, they lack appropriate professional representation with health authorities. The formality of this study will be unique in gathering this information in a
structured and substantiated manner and will, it is hoped, go far to addressing these concerns within the health bureaucracy.

Racism, in particular, is one of the major issues facing most indigenous health workers worldwide (Brady & Carey, 1998). Racism takes many forms and the particular racism I wish to explore in this study has been labelled 'horizontal violence' (Duffy, 1995). One definition of horizontal violence by Spring & Stern (1998) is:

"Harmful behaviour, via attitudes, actions, and other behaviours that are directed towards us by another colleague, horizontal violence controls, humiliates, denigrates or injures the dignity of another. Horizontal violence indicates a lack of mutual respect and value for the worth of the individual and denies other fundamental human rights" (p. 15)

Horizontal violence is recognisable, and definable, causes physical injury, hurt inflicted by another, and sometimes cannot be seen, however there is visible indicators that horizontal abuse goes also with horizontal violence. Horizontal violence, as described above, is a common occurrence with the health professionals, police officers, ambulance offices, and is a big threat to public servants in Australia. Horizontal violence and abuse is said to be rampant within the nursing profession (Spring & Stern, 1998).

The abuse and bullying associated with horizontal violence not only occurs within the workplace but also from the worker’s own community, where they work and live and are not being protected. It may well be argued that some of the issues at work are of an industrial nature, for example the differences between holidays, paid overtime etc. However, in many circumstances, work issues such as lack of resources or isolation are a direct result of the horizontal violence as
defined above.

Without this unification there is little chance of these problems being addressed in the near future. The Second National Aboriginal Health Workers Conference 1997, "Uniting Our Voices" gives evidence of this from participants who stated that the isolation of being a solitary Aboriginal Health Worker within the mainstream health arena left them open to prejudices, discriminatory attitudes and racism from non-Aboriginal health professionals as one of their main concerns. Although a lot of anecdotal stories of racism and lack of recognition can be collected, the formality of this study will be unique in gathering this information in a structured and substantiated manner.

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Before I explain why this project is necessary, I feel it is important to have an understanding of the history of Aboriginal health if we are to understand the current health problems associated with Aboriginal Health Worker's role, the racism encountered in that role, and their lack of professional recognition. It is also important to remain focused on the fact that it was the racist views of the European invaders that led to the deterioration of Aboriginal health and destruction of their traditional health system in the first place. Thus creating the need for the Aboriginal Health Worker and all the accompanying policy rhetoric around the role.

This study will look at the impact of racism on the work of Aboriginal Health Worker’s in contemporary Australia. The study will particularly focus on exploring racism and how it acts as an obstruction to productive work and health outcomes for Aboriginal Health Workers due to the particular problems that it presents those Workers.
Mainstream health services have generally failed to fully recognise and address the continuous poor state of Aboriginal health in Australia. Exacerbating this situation is the failure of health authorities to recognising the potential contribution that Aboriginal Health Worker could make in the delivery of health care to the local Aboriginal community. I expect to find large differences between what management say about the actual job performance of Aboriginal Health Workers and that management’s perceived expectations of them. This has resulted in management and staff attitudes to Aboriginal Health Workers not being expected to change much in twenty years. I intend to draw attention to the continuing lack of knowledge about the function and role of the Aboriginal Health Worker as being the main culprit for these attitudes. Hopefully this will encourage the staff and health services to take positive steps in the education of staff, both allied and clinical, about the role of the Aboriginal Health Worker.

The aims of this project are to demonstrate that an appropriate standard job description would benefit Aboriginal Health Workers within the Sydney metropolitan area and to illustrate the importance of recognising the professional status and significant role that the Aboriginal Health Worker plays within the Health arena. The project should also explain, through the comments of participants, examples of racism experienced by Aboriginal Health Workers and show the detrimental effects this racism has on the Aboriginal Health Workers and the Aboriginal community in general. It will also attempt to identify how horizontal violence causes social disruption in the workplace and Aboriginal communities and the impact this has on Aboriginal Health Workers themselves.
These aims will be achieved by examining previous literature covering the role of, recognition of and racism faced by the Aboriginal Health Worker and the notion of horizontal violence in the workplace. The interviews will also assist in identifying, from the experiences of other professionals, the benefits of a standard job description of their previous positions and explore their experiences and perceptions of these issues.

**The impetus of this research**

This is an important project to me because of my own experiences working as an Aboriginal Health Worker. After reading the articles of Tragenza & Abbot (1995), Grootjans & Spiers (1977) in which the authors describe how the role of the Aboriginal Health Worker has developed over the past twenty years and how the present medical system will not tolerate traditional ways of healing and medicine in its space. These articles confirm that non-Aboriginal people cannot concede their power and policy stances on indigenous health to indigenous representatives. This occurs because health policy development and implementation plays the major role in maintaining the medical establishment’s power over Aboriginal health workers and Aboriginal health in general.

Therefore, changes can only come about when Aboriginal people, themselves, can put policies into place. At present any changes are made at such a high level of the bureaucracy that, for front-line, grassroots health workers there is only the continuous brick walls of opposition fought (Flick 1997).
The racism I wish to make evident in this research study also includes the fact that the worker is exposed to each day by an abuse called 'horizontal violence.' (This abuse will be explained in depth later.) This abuse and bullying not only occurs within the workplace but also from the worker's own community, where they work and live and are not being protected. Some may very well argue that some of the issues at work are of an industrial nature, eg the differences between holidays, paid overtime etc', however many times the differences' causation is through 'horizontal violence'.

The New South Wales Health Department has made commitments to employing Aboriginal people into mainstream services (Department of Health, 1997). The specific job descriptions for Aboriginal people whether employed as Aboriginal Liaison Officers, Aboriginal Health Education Officers, or as Aboriginal Health Worker, still does not have a generic job description and therefore cannot unite as one voice or work together to weld Aboriginal Health Workers in a professional recognised body for the health of Aboriginal people.

During my employment I have noted that there is a lack of consultation with health workers about their professional status, which leads to a lack of recognition of the roles and qualifications that Aboriginal Health Workers have gained.

There is also, in my opinion, which is based on twelve years of experience in the profession, discriminatory attitudes and behaviour by other health professionals, who treat Aboriginal Health
Workers as less than a professional group of workers. Again, not recognising their education and the serious responsibilities they incur on a daily basis.

Without the unification of the Aboriginal Health Workers profession in NSW and across Australia Aboriginal Health Workers will not be able to develop their professional status. In my career I have heard many anecdotal stories of racism and lack of recognition. My study will be unique in gathering this information from and giving a voice to the silent Aboriginal Health Workers.

MY PERSONAL EXPERIENCE

Although there is a body of literature that supports a number of issues raised in this research, there are also some points which are untested opinion and it is these points that I intend to explore and clarify further in this thesis. I would like to know if other people share my understanding of these issues. When I first went into an Aboriginal Health Worker position I felt strong, but the next twelve months was a struggle. Some of the problems I faced were:

- On the first day I went to work, the office was in one ward that had once been used for patients. Out the front were two desks, two phones, two chairs, two pens, two writing pads,
and two rulers. (On seeing these office conditions, I immediately thought management regarded me as their token Aboriginal Worker. These conditions could not compare with those given to other health professionals in the hospital.)

- During the first month I spoke to the supervisor about my pay. I was on a lower wage then when I was nursing. The supervisor instructed me not to speak to anyone about this, especially other Koori people working alongside me (This was a clear lack of respect for the role of the Aboriginal Health Workers )

- Once I was talking about health issues to Koori people and encouraged them to express their feelings, and my supervisors quickly told me not to put words into their mouths. (This immediately created conflict about my responsibilities. Who am I responsible to? The management or the community I serve? This left me, feeling caught between two worlds and not serving anyone)

- All the Aboriginal Health Workers that I have met over the years all spoke about their problems and grievances( every time you got together for a meeting) of nearly identical to the ones from previous Aboriginal Health Workers, every time they would get together I would to the same issues fronting these people each day. (Aboriginal Health Workers have no where to turn to for help when there are grievances about working conditions)

I felt that this struggle was because the bosses didn’t know why the Aboriginal Health Worker was there. The boss quite openly asked, “What’s your plan of attack?” because although they didn’t know why we were there, management still had these huge expectations of you. Although Management regularly arranged new identified positions for the hospitals, it seemed that they
were making up the Aboriginal Health Workers’ roles, as they went along. There were no stated or explicit goals for the Aboriginal Health Workers or to whom or for what they were responsible. When I look back today, I thank God that I had a history of working on the inside of the health system, as an enrolled nurse prior to taking this position.

When I gained the opportunity to write a thesis for the Honours component of the degree I am undertaking, my mind went back to these beginnings for ideas that were important and worthwhile to research for the thesis. I decided that after twelve years of hearing Aboriginal Health Workers talking about the same problems I had encountered, I would give them a chance to express their opinions and concerns about this situation in a way that empowers them and myself and hopefully draws attention to the poor work environment and management practices that we continue to endure.

Therefore this thesis will attempt to draw attention to the lack of continuing knowledge about the function and role of the Aboriginal Health Worker. Using this academic medium may encourage staff and organisations involved in delivering health services to Koori people to take positive steps to educate management and clinical staff about the role of the Aboriginal Health Worker in NSW. This will, I hope encourage Health Professionals and Management to be more sensitive and to have a deeper understanding of the role of the Aboriginal Health Worker. The thesis will attempt to give the reader Aboriginal Health Workers’ perspectives on the major issues that five other Aboriginal Health Workers have experienced and that we continue to experience in our day to day working lives.
Throughout this thesis I have used the term Aboriginal Health Worker. I recognise that nationally, the given term for the profession would be Aboriginal and Torres Strait Islander Health Worker. However, because the research is limited to NSW and I believe, should be a choice for Torres Strait Islander people to choose inclusion, I do give them that option. Where I speak of Aboriginal people generally, it is for brevity that I do not use Aboriginal and Torres Strait Islander at each occasion, rather than exclusion of Torres Strait Islander peoples. Identifying commonalities between the two groups is beyond the scope of this current project and will have be the subject of further inquiry by others in the field.

CHAPTER 1
Introduction

1.1 Importance of this research

It is important to have an understanding of the history of Aboriginal health if we are to understand the current health problems associated with Aboriginal Health Workers role, the racism involved, and their lack of recognition. It is also important to remain focussed on the fact
that it was the racist views of the European invaders that led to the deterioration of Aboriginal health and destruction of the Aboriginal traditional health system.

This study will look at the impact of racism on the work of Aboriginal Health Worker’s in contemporary Australia. The study will particularly focus on racism as an obstruction to productive work and health outcomes (and whether or not support is given to Aboriginal Health Workers), due to these particular problems that the workers face.

Mainstream health services have failed to improve the continuous poor state of Aboriginal health by the obstruction of not recognising the potential Aboriginal Health Workers could assist with the health care delivery to the local Aboriginal community. The importance of this non-recognition to this project is for non-Aboriginal people to gain an understanding of the incentive behind this obstruction.

I expect to find that there will be a large difference between what Management say about Aboriginal Health Workers and the perceived expectations of them. Management and staff attitudes to Aboriginal Health Workers are not expected to have changed in twenty years. I intend to draw attention to the lack of continuing knowledge about the function and role of the Aboriginal Health Worker. Hopefully this will encourage the staff and health services to take positive steps in the education of staff, both allied and clinical about the role of the Aboriginal Health Worker.
1.2 The research problem

There are four main areas within the domain of this research problem, each with their own question to be answered within this project:

The Role of the Aboriginal health worker; Although the title of 'Aboriginal Health Worker' has been utilised since the early '70s, going into the new millennium there is still no standard job description for the role of the Aboriginal Health Worker. How do Aboriginal Health Workers feel their role has been defined?

While Hospital Liaison officers and Health Education Officers play different roles they support each other in activities which involve community people. The two major employers of Aboriginal Health Workers are Aboriginal Community Controlled Services (ACCS) and mainstream Area Health Services. When the ACCSs were established in the early Seventies (Foley, 1991) Redfern Aboriginal Medical Service gave a concrete foundation for the model of the now thirty-two Aboriginal Medical Services across NSW to follow. The management of the Aboriginal organisations and the mainstream services are very different. In the seventeen NSW Area Health Services, all have different 'westernised' models of health management. These include health promotion, different treatment regimes, acute care, rehabilitation. The overall
Public Health Sector Management model has an unclear role of both Aboriginal Health Workers and are quite fragmented by the range of different operational units in which Aboriginal Health Workers are situated.

2) Recognition. There are a number of professional programs and courses specifically designed for Aboriginal people supposedly to empower them in the helping professions and there are numerous mainstream courses undertaken by Aboriginal Health Workers. However, immaterial to the qualifications held by an Aboriginal Health Worker, the status of the Aboriginal Health Worker remains very low within the health arena, Aboriginal Health Workers have no voice in any decision making and are not treated as professionals.

3. Racism. Aboriginal Health Workers are exposed to racism within the workplace routinely. Worse than not being recognised as a professional person, Aboriginal Health Workers are regularly subjected to scrutiny of their work and time to a much higher degree than other health workers.

4. ‘Horizontal violence’. Aboriginal Health Workers also face horizontal violence not only within their workplace to a higher degree than most other professionals, but they also face it within their own communities. Horizontal violence can take many forms and may be directed in particular against women and ethnic minorities or towards people because of their age, sexual orientation, physical or mental disability, or some other characteristic—eg being competent and popular. It may involve action, behaviour,
comment or physical contact which is found objectionable or which causes offence; it can result in the recipient feeling threatened, humiliated or patronised, and it can create an intimidating environment. (Friere, 1974)

1.3 The questions I will be asking:

• How do Aboriginal Health Workers feel their role has been defined?
• How has a lack of professional recognition for Aboriginal Health Workers impacted on the self-esteem of Aboriginal workers?
• How has the Aboriginal Health Worker role been affected by Racism?
• How do Aboriginal Health Workers experience ‘horizontal violence’ (definition on page p66) and how much does this impact upon and effect their professional and personal lives?

1.4 Importance of This Research

Before I explain why this project is necessary, I feel it is important to have an understanding of the history of Aboriginal health if we are to understand the current health problems associated with Aboriginal Health Worker’s role, the racism encountered in that role, and their lack of professional recognition. It is also important to remain focused on the fact that it was the racist
views of the European invaders that led to the deterioration of Aboriginal health and destruction of their traditional health system in the first place. Thus creating the need for the Aboriginal Health Worker and all the accompanying policy rhetoric around the role.

This study will look at the impact of racism on the work of Aboriginal Health Worker's in contemporary Australia. The study will particularly focus on exploring racism and how it acts as an obstruction to productive work and health outcomes for Aboriginal Health Workers due to the particular problems that it presents those Workers.

Mainstream health services have generally failed to fully recognise and address the continuous poor state of Aboriginal health in Australia. Exacerbating this situation is the failure of health authorities to recognising the potential contribution that Aboriginal Health Worker could make in the delivery of health care to the local Aboriginal community. I expect to find large differences between what management say about the actual job performance of Aboriginal Health Workers and that management's perceived expectations of them. This has resulted in management and staff attitudes to Aboriginal Health Workers not being expected to change much in twenty years. I intend to draw attention to the continuing lack of knowledge about the function and role of the Aboriginal Health Worker as being the main culprit for these attitudes. Hopefully this will encourage the staff and health services to take positive steps in the education of staff, both allied and clinical, about the role of the Aboriginal Health Worker.

The aims of this project are to demonstrate that an appropriate standard job description would
benefit Aboriginal Health Workers within the Sydney metropolitan area to illustrate the importance of recognising the professional status and significant role that the Aboriginal Health Worker plays within the Health arena. The project should also explain, through the comments of participants, examples of racism experienced by Aboriginal Health Workers and show the detrimental effects this racism has on the Aboriginal Health Workers and the Aboriginal community in general. It will also attempt to identify how horizontal violence causes social disruption in the workplace and Aboriginal communities and the impact this has on Aboriginal Health Workers themselves.

1.4 The Purpose of this Research

These aims will be achieved by examining previous literature covering the role of, recognition of and racism faced by the Aboriginal Health Worker and the notion of horizontal violence in the workplace. The interviews will also assist in identifying, from the experiences of other professionals, the benefits of a standard job description of their previous positions and explore their experiences and perceptions of these issues.

To do this, I will:

• identify, from the experiences of other professionals, the benefits of a standard job description within their fields.

• examine relevant literature covering the role, recognition and racism of the Aboriginal Health Worker.

• examine relevant literature on 'horizontal violence'.

• interview past and present Aboriginal Health Workers on their experiences within the Health
arena relating to their perceptions of their role, the recognition of the position, racism and ‘horizontal violence’.

1.5 Thesis outline

Chapter Two, Methodology describes the problems attempting to research Aboriginal people by an Aboriginal person whilst adhering to mainstream or non-Aboriginal research methodology. In one sense this research is Ethnographic in that the researcher is an Aboriginal Health Worker, lives in an Aboriginal community and shares the same experiences as the participants of this research. However, because Aboriginal Health Workers had to be interviewed, through a qualitative mode, under a model of grounded research to provide a rigorous, systematic analysis of qualitative data with the aim of generating new theory, particularly in relatively unresearched area I chose. The interviews were conducted as unstructured and audio recorded. Limitations of the research, ethical considerations, data analysis and outcomes are also discussed.

Chapter Three, titled The Role of the Aboriginal Health Worker describes the expectations of management of the mainstream health system and Aboriginal communities of Aboriginal Health Workers and the problems this generates. It also gives evidence of the lack of consistency of these expectations, the lack of autonomy and the lack of any generic job descriptions for Aboriginal Health Workers.
consistency of these expectations, the lack of autonomy and the lack of any generic job
descriptions for Aboriginal Health Workers.

Chapter Four, *The Recognition (& Status) of Aboriginal Health Workers* illustrates the lack
of recognition of the skills and expertise of Aboriginal Health Workers through past work, the
interviews and the researchers personal experience.

Chapter Five, *Racism (& Discrimination) against Aboriginal Health Workers* demonstrates
the racism and discrimination experienced by Aboriginal Health Workers within the
workplace.

Chapter Six, *Horizontal violence* describes the racist behaviours and gender harassment that
are all forms of discriminatory behaviours which can include a wide range of conduct and
causes another person to feel offended, humiliated, intimidated, insulted or ridiculed. gives
a definition (p66) of this insidious obstacle for Aboriginal Health Workers, describes
‘workplace bullying’, the subordination encountered by Aboriginal Health Workers through
this subjection and gender issues with the scope of horizontal violence.

Chapter Seven is the *Conclusions of the Research.*
CHAPTER TWO
Methodology

2.1 Introduction

To find a research paradigm that would give voice to matters of import to Aboriginals to very close to impossible. To do so would require a holistic paradigm that reflects Aboriginals’ cultural practices and normative behaviour. (West, 1997)

The study of the Aboriginal Health Workers within non-Aboriginal society challenges the classical dimensions of sociological research. Researchers are prompted to exploit the possibilities offered by new, powerful, and flexible analytic tools for inexpensively collecting, organising, and exploring data. To aid in systematic examination of logs and tapes taken from the research, tools need to be found that can incorporate an Aboriginal perspective, especially when the researcher is Aboriginal. A proposal could then be made for a strategy of research which systematically compares Aboriginal specific aspects over different ‘Westernised’ outlooks and different socio-geographical contexts. (West, 1997)

While making decisions about methods to undertake this research I found the majority of methods too formal, limiting or simply unsuitable for the type of research I contemplated and culturally inappropriate for me and the participants. Methods such as questionnaires would not give me the depth of information I was hoping to find. Searching literature was also limited, as there was very little information about Aboriginal Health Workers in New South Wales.


2.2 Limitations

One limitation, which I needed to consider, before doing this research, was the geographical location. I have chosen the metropolitan area of Sydney. I chose this because it had the least financial and social burden.

I had personal knowledge about who had worked as a health worker and who had resigned, I used this knowledge to contact a few of these people and asked them to participate in my research by being interviewed. I was concerned, that there would not be enough people around willing to share their stories with me.

I feel that, had I been a non-Aboriginal researcher my results would have been different as I would not have got a true picture of the problems associated with the personal lives and work related issues that is shared by each and everyone of the participants. I am an Aboriginal person who shares a culture and a lifestyle with the participants and this brought about high level of comfort for the interviewees during the interviews (Yunupingu, 1994).

In his lecture, Yunupingu explains:

“For Balanda, [white fella]brackish water is distasteful. But for us the sight and smell of brackish water expresses a profound foundation of useful knowledge – balance. For Aboriginal people brackish water is a source of inspiration. In each of the sources of flowing water there is ebb and flow. The deep pool of brackish water is a complex dynamic balance. In the same ways, balance of Aboriginal life is achieved through ebb and flow of competing interests, through our elaborate kinship system. Gamma is a metaphor. We are talking about natural processes but meaning at another level. Gamma is social theory. It is our traditional profound and detailed model of how what
2.3 Methodologies

Ethnography is to assemble an account of the way in which those being studied manage and organise their lives as natural social actors rather than as some homunculi of sociological theory, by trying to obtain an 'insider's' view of the setting. It is this ambition which necessitates the researcher becoming involved in the setting and the activities being studied in order to gain the same perspective, as far as this is possible, of the actors concerned.

This research applies ethnographic theory and practice to communication and cultural issues, with an Aboriginal Health Worker as the researcher. It examines main perspectives in the Health system that have shaped conceptual boundaries of communication and cultural allowances given to Aboriginal Health Workers and the historical and cultural contexts of the development of the role of the Aboriginal Health Worker.

A qualitative approach using a descriptive study design was adopted in order to facilitate this study. A sample of five selected participants of who were all ex-Aboriginal Health Workers joined the research project. The qualitative method of theme extraction was employed for data analysis which led to the emergence of themes which were grouped and compared to each other (Strauss & Corbin, 1990). The findings were contrasted with relevant literature in the field to fully understand the phenomenon under study. Grounded theory is an inductive qualitative methodology developed by Glaser & Strauss (1967) to provide a rigorous, systematic analysis of qualitative data with the aim of generating new theory, particularly in relatively unresearched
areas. Emphasis is placed on participants' own accounts of events and experience. Grounded theory enables researchers to find structure in data by discerning and analysing emergent data patterns (Glaser & Strauss 1967; Strauss & Corbin 1990).

In this research, the absence of any previous research in this particular area, and the subjective, experiential nature of the material lent itself well to the application of grounded theory methodology. In essence this was a largely exploratory study.

2.4 The Interviews

By its own definition, unstructured interviews have no guidelines or rules to follow, which leads the interview into new, sometimes murky territory. Fontana and Frey (1994) clearly illustrate the essential difference between structured and unstructured by stating that structured interviews are used to define predetermined categories of behaviour, while unstructured interviewing tries to define the behaviour itself, without any preconceived notions of what it could be. In other words, structured is the "what" and unstructured is the "why". In this method, the researcher becomes less of an interviewer and more of a detective, not confined to the rules of traditional interviewing. Fontana and Frey provide a generic procedure of unstructured interviewing, explaining that this is just a format whose elements are not followed by all who undertake this method of research.

Accessing the setting, the researcher concerns themselves with getting inside the environment, immersing themselves in the atmosphere of the interview. Understanding the
language and culture of the participants, normally a difficult process, in which the researcher must not only acquaint themselves with the vocabulary, but the meanings behind what is said and the cultural implications of certain responses. Biases and inaccurate interpretations can be problematic in this step, however because of my commonalities of culture, language and work experiences with the participants these issues, although important were not problematic.

Gaining trust, without established trust, the researcher could not get accurate responses and opinions, especially concerning sensitive issues, again this was not problematic because of our similar and familiar backgrounds. The interviewer walks a fine line in this process, wanting to establish a bond with the subject(s), yet trying to remain objective for the good of the research. I have to be very aware of this concern throughout the research, which I have viewed as a limitation that only my awareness and continual vigilance to remain objective can overcome.

After spending twelve months searching for and reading the limited literature I found about Aboriginal Health Workers I proceeded to carry out the interviews. The difference between what my participants spoke to me about and the government rhetoric about Aboriginal Health Workers was a perfect example of the Rhetoric & Reality written about by Tregenza & Abbott. The reality that the participants spoke to me about was that Aboriginal Health Workers were facing horizontal violence and abuse on a daily basis which lead to them leaving their employment. I have chosen not to write a separate Literature Review and instead have used past works to
reiterate my arguments throughout the thesis. This decision was made in consultation with my Supervisor.

The interviews were open and unstructured and plenty of time was given for the participants to share their stories with me about their experiences of being an Aboriginal Health Worker. Each of the interviews was conducted in private, mostly in bush settings such as in a park. In their book 'Basics in Qualitative Research', Strauss & Corbin (1990) dedicated an entire chapter to unstructured interviews with an emphasis of consideration for the participants.

The participant's first reaction to being interviewed was often just laughter about talking into the microphone. The participants began with overwhelming feelings of anxiety about being interviewed for the first time, as they had never done this before. The process of interviewing after a short while became quite comfortable.

My participants included one male and four females this is because in the Aboriginal Health Workers profession the dominant gender is female. All participants were over thirty years of age. I chose people from different area health services so this would create an even balance. These people were chosen because each had worked as Health Workers and left their positions. I felt that this particular group could offer particular insights into the way they had been treated and as to why they had left the profession. I also knew that because they no longer worked within the system, that they would feel able to speak openly about their experiences.
The interviews did not involve any written material except for the consent form. These participants set the scene, so that they could be at ease with the process and they began talking, telling their stories of their time working as Aboriginal Health Workers. Not surprisingly, they answered the questions that I was researching about role, recognition, racism and horizontal violence of the Aboriginal Health Worker without any prompting.

2.5 Ethical Considerations

While unbiased interviewing and interpretation protect the research, the ethics of interviewing protect the recipient and should be taken seriously by the interviewer. Informed consent, right to privacy and protection from harm are the major concerns of researchers in the social sciences, yet not the only ones. Debated ethical considerations include legal implications of actions taken while the interviewer is immersed in an environment and has established rapport with the subjects, and the problems of objectivity.

Each participant will be informed of the purpose of the study. Participants' personal contribution together with their human rights will be explained and the opportunity to ask questions about the study will be provided. Once the participant is satisfied with the requirements of the study, a consent form will be signed. The consent outlines the purpose of the study, its voluntary nature, the right to withdraw at any time without penalty, as well as providing an assurance that all information provided will be treated in a non-identifiable, confidential manner. The consent form will be signed by the participant and the researcher,
and a copy will be kept by each.

Participants will be identified on the interview transcript by a numerical number. The identity of the participants will be known only to the researcher who will keep names and workplace details in a secure place, separate to the transcripts (this information will be required if further contact is necessary). In keeping with the requirements of the University, the transcribed interviews and field notes will be kept for a period of five years.

2.6 Data Analysis

After completing the recordings I returned home where I could transcribe the interviews. Copies of the transcribed recordings of the interviews were given back to the participants with follow up telephone conversations to confirm that the transcripts were a true and honest account of what the participants had intended to say. One participant chose e-mail for follow up. As Neuman (1991) suggests that little attempt is made to follow up these participant reports to see whether they are actually satisfied with the results, which if made, adds to the authentication of the research. For a variety of reasons we do not always take these extra steps in certain situations. I have wondered whether this explained some of the confusion in the literature. (Neuman, 1991).

When I made follow up phone calls to the participants about their transcripts, they were quite happy with the way I had transcribed their comments. Participants generally commented that
they wished that they could have had more time, because they had thought of many new things to say after the interview had taken place.

The next step in this research was to code the transcripts. I read and listened to each interview on several occasions, looking for the common and stand out themes that the participants had introduced. I also attempted to identify any significant points made by participants that related to the role recognition, racism and horizontal violence questions. These codes were then narrowed down to the most significant points made by the participants (Silverman, 1993).

At some point in the future I would like to do a survey similar as this one, across NSW to collect the oral stories from a larger group of people. It is clear to me after talking to this group that there are many more Aboriginal Health Workers out there keen to share their stories with me and one could imagine that these stories all share the same feelings, the pain, the joy, the loneliness and some, the inspiration to go on. They all share the most fundamental issue: they are all Aboriginal.

I share lots of common issues with the people that I am interviewing, I am an Aboriginal Health Worker and share all the grievances these people are talking about, not only do I share their work experience, I also work and live in the same community. Hearing their voices in regards to their employment and the years of struggle and abuse is only to familiar, I can relate to every thing that they say, and finally to listen about them not working. Being involved as Aboriginal Health Worker makes you want to clarify the issues that they have concerns about.
When I listened to the tapes a couple of times and compared the themes from each participant, the themes reinforced the commonality from all interviewees that the Aboriginal Health Workers were facing institutional violence and horizontal violence. My research became more unmatched due to the lack of written materials and information about the real problems confronting Aboriginal Health Workers. This thesis became more of a challenge, not only for myself, but also to give Aboriginal Health Workers a voice.

2.7 Outcomes

I have achieved excellent results from the participants, with the optimistic freedom of-collecting information in a traditional manner. I was able to extract a lot more information that was vital to this project. I feel that if I were a non-Aboriginal Health Worker I would not have been able to achieve these results.

I still didn’t know why I didn’t feel surprised when I picked up the Aboriginal Health Worker Journal for 1978 and found that it contained information on the first Aboriginal Health Workers conference, in Darwin in 1978. During my follow up research for more conference results I was shocked to see that there was not another National Aboriginal Health Conference for nineteen years. To my understanding National Conferences are supposed to be held each four years. I was shocked to find that Aboriginal Health Workers from the 1995 conference were still asking for workplace conditions and training identical to those that the Aboriginal Health Workers were asking for, nineteen years earlier. Nothing has changed in those nineteen years. Some of the main issues were:
The lack of a generic job description/qualifications of Aboriginal Health Workers;

Not been recognised as a professional;

Not listening to the wisdom of Aboriginal Health Workers in planning and policy making.

It was with all these considerations running through my mind that I brought together all the information I had gathered from personal experience, the literature and the interviews to write the following chapters (respectively) about:

- The expected roles of an Aboriginal Health Worker;
- The lack of recognition within the professional Health arena experienced by Aboriginal Health Workers;
- The daily experiences of racism endured by Aboriginal Health Workers; and
- The ‘horizontal violence’ experienced by Aboriginal Health Workers in the workplace and in the community in which they lived.
CHAPTER THREE
The Role of the Aboriginal Health Worker

3.1 Introduction

Although the title of 'Aboriginal Health Worker' has been utilised since the early '70s, going into the new millennium there is still no standard job description for the role of the Aboriginal Health Worker. How do Aboriginal Health Workers feel their role has been defined?

Aboriginal Health Workers play an important role in the Aboriginal community and hospital system. They should provide culturally appropriate health services and programs. In the mainstream health system, they are required to provide support and education, and to assist Aboriginal people access mainstream services.

While Hospital Liaison officers and Health Education Officers play different roles they support each other in activities which involve community people. The two major employers of Aboriginal Health Workers are Aboriginal Community Controlled Services (ACCS) and mainstream Area Health Services. When the ACCSs were established in the early Seventies (Foley, 1991) Redfern Aboriginal Medical Service gave a concrete foundation for the model of the now thirty-two Aboriginal Medical Services across NSW to follow. The management of the Aboriginal organisations and the mainstream services are very different. In the seventeen NSW Area Health Services, all have different 'westernised' models of health management. These include health promotion, different treatment regimes, acute care, rehabilitation. The overall Public Health Sector Management model has an unclear role of both Aboriginal Health Workers
Area Health Services, all have different ‘westernised’ models of health management. These include health promotion, different treatment regimes, acute care, rehabilitation. The overall Public Health Sector Management model has an unclear role of both Aboriginal Health Workers and are quite fragmented by the range of different operational units in which Aboriginal Health Workers are situated.

Aboriginal Health Workers play an important role in the Aboriginal community and hospital system. They provide culturally appropriate health services and programs. In the mainstream health system, they are required to provide support and education, and to assist Aboriginal people access mainstream services. While Hospital Liaison officers and Health Education Officers play different roles they support each other in activities which involve community people.

The two major employers of Aboriginal Health Workers are Aboriginal Community Controlled Services (ACCS) and mainstream Area Health Services. When the ACCSs were established in the early Seventies (Foley, 1991) Redfern Aboriginal Medical Service gave a concrete foundation for the model of the now thirty-two Aboriginal Medical Services across NSW to follow. The management of the Aboriginal organisations and the mainstream services are very different. In the seventeen NSW Area Health Services, all have different ‘westernised’ models of health management. These include health promotion, different treatment regimes, acute care, rehabilitation. The overall Public Health Sector Management model has an unclear role of both Aboriginal Health Workers and are quite fragmented by the range of different operational units in which Aboriginal Health Workers are situated.
To make ‘main-stream’ health services Koori friendly for the Aboriginal people, the reasoning followed that by integrating Aboriginal Health Workers into mainstream services, there would be, at least a friendly face and someone that understood their problems. Internationally the push to employ Aboriginal people began from the World Health Organisation in the Alma Arta declaration (WHO, 1978.). The principles of primary health care adopted as policy in Australia led to Various Health Departments committing themselves to employing Aboriginal Health Workers.

Aboriginal Health Workers skills do not just lie in their ability to collaborate with mainstream services, they must come from the community, sharing the communities aspirations, burdens and joy’s (Tragenza and Abbott 1995, p23.). It is the Aboriginal Health Worker that can take their knowledge from the mainstream services that which is useful and then blend it with their own knowledge and the community understanding to achieve better health outcomes for the community people. These workers have the ability to do this, to make an impact on the poor Aboriginal health statistics, but they never get recognised for this potential (Reid and Trompf, 1991 p406).

The Aboriginal Health Worker’s role will vary from one area to another. Different communities will expect the Aboriginal Health Worker to have skills in clinical care, whilst in other communities, the community may not think that clinical skills are required. However, the new Aboriginal Health Worker does not have any credibility in a community and it is important for
them to be able to work with an established Senior Aboriginal Health Worker until they can build their own skill base up and gain status within the community.

Communities usually have a say in choosing their health worker but this too can sometimes be a disaster. Sometimes a person is chosen more because of family ties rather than on merit selection. Sometimes a person comes from a different area and doesn’t ‘fit in’ with the community. The Aboriginal Health Worker selection process may also vary from area to area, however careful consideration should always be taken with selection committee members. Non-Aboriginal society can look upon the former situation as nepotism, however family obligation and kinship reciprocacy is also extremely important in Aboriginal communities. Due to different communities requiring different roles of their Aboriginal Health Workers, there also needs to be consideration of these roles taken before advertising, let alone decisions of training. ‘Before a training program is developed, the role of the health worker should be defined’ (Reid and Trompf, 1991 p407).

While looking for articles for my research I came across very little on Aboriginal Health Workers in New South Wales. However I picked up articles from the Northern Territory on Aboriginal Health Workers (Cawte, Baglin & Reid 1996, Grootjans & Spiers 1997, Abbott and Fry, 1998). One report, which was especially interesting, was by John Tregenza and Cathy Abbot, called “Rhetoric and Reality”.

Tregenza and Abbott (1995), indicate that there should to be an association among Aboriginal Health Workers across Australia, and also describe the myriad of problems in Central Australia.
which I believe hold true across Australia. Most of the issues raised in this article relate to the lack of recognition and status of the Aboriginal Health Workers.

In all types of health services conflict seems to stem from the differences in expectations of the non-Aboriginal health professionals, the community and the Health Workers. This furthers difficulties for the Aboriginal Health Workers (Trengza and Abbott 1995 p6).

Aboriginal Health Workers are often the first point of contact for Aboriginal people with the health care system. (Flick, 1997) This is a key role, which is played by the health worker for the delivery of health care to Aboriginal communities. Little attention is being paid by the wider health system to this important contribution which Aboriginal Health Workers make to the health and well being of Aboriginal communities. Government, health professionals and the wider communities poorly understand their role. The role definitions have been a source of ongoing contention.

“In a number of programs, the role of the health workers has been inadequately defined and this has led to problems for workers leaving their courses.” (Reid and Trompf, 1991, p408)

‘In 1989, the “National Aboriginal Health Strategy”, working party recommended the development of uniform, accredited courses for Aboriginal Health Workers’ (Reid and Trompf, 1991 p407)

The issues raised by Tragenza and Abbott were later supported at the Second Aboriginal and Torres Strait Islander Health Workers Conference in Randwick (1997) as one of the primary recommendations under, ‘Health Worker professional status and representation’.

42
The reason for is that other health professionals want to maintain their own professional power within the health care system. This is achieved by turning a blind eye to professional problems being faced by Aboriginal Health Workers. The production of excellent rhetoric by NSW health, regarding what Aboriginal Health Workers should be about, is one step, but this rhetoric does not include any practical reality about how these ideas should be implemented. This simply evidences more lip-service with no actions.

3.2 Issues impacting on Aboriginal Health Workers' role.

The participants involved in the interviews (as described in the Methodology Chapter) spoke about the many issues that confronted them on a daily basis, which lead to their resignations. Their stories that I shared, caused me great emotional stress. Although the participants told me many things, the two major themes which made me sit up and take notice are explained here:

3.2.1 Management verses culture.

The role of the Aboriginal Health Worker has often been described as a brokerage between Aboriginal and non-Aboriginal culture. This is seen by many as employing Aboriginal people to facilitate other Aboriginal people having a less stressful passageway into the health care system.

"In the role of cultural broker, the Health Worker is the go-between, the link between the health services and the community, the person in the middle of, and participating in, and two cultures".
The idea that an important role for Aboriginal Health Workers is as a go between, is clearly specified in the competency standards set out for Aboriginal and Torres Strait Islander Health Workers. (National Community Services and Health Industry Training Advisory Board, 1996)

Health Workers are also primarily responsible to their local community and may have responsibilities to integrate western and traditional health approaches and to manage difficulties emerging from this integration. National Community Services and Health Industry Training Advisory Board, 1996 p25

“This rhetoric is powerful and said so often, it clearly places Aboriginal Health Workers in position of leadership and authority in this aspect of health care.” (Coaby, 1984)

The Alma Ata declaration goes as far as to suggest that this role for Health Workers is essential to attaining health for all (WHO, 1978). This implies without Aboriginal people working as cultural brokers, Aboriginal people’s health will not improve.

This issue brought great hardship for many workers who attempted to stay true to their communities while trying to remain employed by government departments which did not understand or respect the nature of the obligations which this commitment would bring to the workers.

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Health Workers are also primarily responsible to their local community and may have responsibilities to integrate western and traditional health approaches and to manage difficulties emerging from this integration. (National Community Services and Health Industry Training Advisory Board, 1996, p7)

The Alma Ata declaration goes as far as to suggest that this role for Health Workers is essential to attaining health for all (WHO, 1978). This implies without Aboriginal people working as cultural brokers, Aboriginal people’s health will not improve.

Langford (1978) suggests;

“*The Department stated that many Aboriginals do not seek health care because they fear the strange hospitals and doctors surgeries. They are not familiar with non-Aboriginal ideas of illnesses and are being sensitive about being misunderstood.*” (p.17)

The conflict created by this tension between the demands of management and the needs of the local community will be further elaborated on in the Results section.

The participants have made it very clear that this is one of the major problems confronting them in the workplace. One poignant comment from the one of the participants, which struck me, was, “you’re dammed if you do, and your dammed if you don’t!” (Participant One).

As this comment was explained to me, this person would go out into the community and be ‘shamed’ by various members of the community, on occasions this shame was not even by members of their own community. Shame, is one of those things that causes great anxiety for Aboriginal people, especially when that shame is associated with behaviour that is perceived as
‘Gubba’ (non-Aboriginal person) behaviour, or acting non-Aboriginal. Then when returning to work, non-Aboriginal people at the office, who do not understand Aboriginal culture, criticise you, they do not realise that what they are criticising you for is being ‘Koori’.

Aboriginal people are forced to wear two hats. They are required to represent the health department and it’s policy initiatives but this often conflicts with their representing the communities that they are intended to serve.

One participant said;

"I did feel that I was on my own, because often services were saying, ‘you work for them not for us’." (Participant Two). Another said, “The normal abuse from the Aboriginal community of, ‘you’re never there’, or ‘you just drive around in your flash car with your mobile phone’.” (Participant One).

These people giving examples of the typical shame from both sides. The first account is the shame caused by the employer the second account is the shame caused by the community.

Another reason for conflict between management and Aboriginal Health Workers was the physical boundaries, which are different between cultures. Non-Aboriginal people are more territorial about physical space, while Aboriginal people are more transient and flexible in the way they use each location. This caused conflict to some of the participants when the departmental boundaries do not coincide with cultural boundaries. This placed pressure on the participants when they were restricted to departmental boundaries but the communities expecting them to operate outside their given boundaries, One said, “The land owns us, we don’t own the land” (Participant Four), how can Aboriginal Health Workers stick to a set a arbitrary rules.

46
The Aboriginal Health Worker is ultimately responsible to the Aboriginal communities because their positions are identified, therefore community members often feel as though they own the Aboriginal Health Worker and this ownership is tied closely to their credibility or capacity to assist individuals in the community. Aboriginal culture emphasises sharing, caring and privilege is frowned upon, Thus community members can easily draw on the notion of “privilege” to shame Aboriginal Health Workers who appear to be above their rank in the community.

One Participant was willing to break the law to help her/his people.

‘I stole food for my people just so that they could have food in their belly for the long cold night ahead of them’ (Participant Five)

Kinship responsibilities and ties continue to be a powerful element of Aboriginal culture, which continues to obligate Aboriginal people all around Australia. The above response is an example of just how far one Aboriginal Health Worker was willing to go to fulfill their obligations to the family. Conflict between kinship responsibilities and departmental responsibilities is common. This creates tension with the Aboriginal Health Workers, which often leads to the Aboriginal Health Worker resigning from the position.

The participants showed that they really cared about their people and were willing to go to great lengths to help them. The following response is a further example of the conflicts impacting on Health Workers on a daily basis.
“When I applied for this job I thought I was going to be helping my people. I am a real people person, I came from a background of pulling beer’s. The only place that I could get support to do my job, as I saw it was to go down to the medical centre, but when I got back to my work place I was told that I was doing the wrong thing.” (Participant Three)

These participants show the conflict that Aboriginal people face when they come into contact with the Western medical system. The non-Aboriginal people seem unwilling or unable to respond to the needs of Aboriginal workers. These participants experiences are the end point of non-Aboriginal ethnocentrism, where all that can be understood by non-Aboriginal people is their own culture, with an unwillingness or inability to learn, understand and respect Aboriginal culture. This is taken to an extreme, one Participant spoke about an occasion when a non-Aboriginal person was speaking to an Aboriginal worker about Aboriginal culture the response from the non-Aboriginal worker was, “…you mean to tell me there is more.”. (Participant One)

3.2.2 Management and health policy.

The Western model of health care is based on biomedical practices and coloured by neo-liberal principles, which focus on data, income generation and cost recovery. Managers are interested in how many people you can get in, and then how quick you can get them out, of the hospital system. This causes conflict for Aboriginal Health Workers who try to deal with patients holistically while attempting to conform the neo-liberal demands of the health bureaucracy.

The NSW task force report titled ‘The Last Report’ adopted a definition of health which supports a Koori perspective;
"... Not just the physical well being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-way-of-life view and it also includes the cyclical concept of life-death-life". (NSW Task Force on Aboriginal Health, 1990 p 12-13)

The Task Force went on to state;

'To work for significant improvement in Aboriginal infant and adult health by encouraging communities to take more responsibility for their own health' and 'to enable and encourage communities to use existing health services'" (p 12-13)

The rhetoric of this report is clear they state that Aboriginal people need to be self determined in the management of their own health. However, the participant’s comments have indicated to me that the reality is that this does not happen because bosses set them up to fail and do not have a clear understanding of cultural issues.

One Participant said,

"we are talking about reconciliation, and we are being put into these jobs but are being set up to fail" (Participant Three)

This worker is talking about the employment of Aboriginal people to do a particular job, to improve the health of Aboriginal people. And while the rhetoric is fine in this Aboriginal Health Workers point of view, barriers are constantly created to prevent this program from being successful.

The Health Workers who were interviewed indicated that there is an unwillingness of health managers to listen to Aboriginal cultural ways of doing things within their community. This has
detrimental effects on the health status of Aboriginal people, if Aboriginal people can not do what the rhetoric suggests they should do then Aboriginal health will not improve.

This statement by one Participant helps clarify this issue.

'I was under the supervision of this absolute #*#*, who didn’t have any idea of what it took to be a supervisor of Aboriginal Health Workers. I asked her one-day have you ever worked with Aboriginal people before? The managers response was ‘no, and that has nothing to do with this issue’, I had also asked had she done any cultural awareness training and her response was ‘no, and I don’t have any intentions of doing so’.” (Participant One)

This manager felt that this Aboriginal worker should be treated like all the others. The manager did not feel that an awareness of cultural issues would help improve the way she managed the Aboriginal staff in the Unit. This single event shows that the rhetoric of the Last Report is not being put into practice. As far as this manager was concerned it was OK to employ Aboriginal people as long as they acted Gubba, this flies in the face of self-determination.

“'A couple of years ago an Aboriginal Health service in remote Australia tried to explain some of these things in a submission to government. Quite clearly, the bureaucrats sitting in their plush Canberra offices had no idea of what Aboriginal Health services was saying and less interest in taking the time out. The decision was made to offer exactly half of the funds requested for the project, which would have made it impossible. The community organisation refused the offer. It was clear that the bureaucrat who had made the decision had one so with little or no thought to the potentially lethal implications of the refusal. According to the bureaucrats, the submission did not fall within the appropriate guidelines.”” (Flick, 1995. p11)

This is a perfect example of the problems Aboriginal people face with bureaucrats. They often don’t give clear direction to the Aboriginal Health Worker of what they want. As one of the
previous participants suggested this lack of information sets Aboriginal people up to fail. How can Aboriginal Health Workers be empowered with non-Aboriginal managers controlling and moving the goal posts all the time?

The managers have huge expectations of the Aboriginal Health Workers and cut them down when things fail. As Ah Kit (1991) has suggested “the right to make mistakes” and the right to learn from these mistakes is an essential element of self-determination.

“How can people learn, how can they develop self-determination except through control and the mistakes it inevitably entails. We should also remember that the non-Aboriginal health care system is in absolutely no position to criticise Aboriginal mistakes.” (p. 53)

Ah Kit's (1991) comments are made all the more clear when we see the impact of the inability of managers to understand self-determination at the grass roots level. As one Participant has stated:

“Like my old boss I had was a real pain, she put a lot of negative stuff on me, a real lot, and I sort of think that a lot of people would not have worn that, but I did. I put up with this for a long time and handled it ok, the non Aboriginal way, but by this time I was coming into their ways of performing, and then I wanted to throw my job in plenty of times”. (Participant Three)

Another Participant stated:

“I shared my office with the domestic violence office, she was telling me about her budget and how she had recurrent funding and that I should be approaching my boss to gain information as to the health budget, I did and asked he said “none”. (Participant Four)
The cultural expectations of community members may not be met by the Aboriginal Health Worker because of lack of resources and a lack of support. The support that is needed is a true understanding of self-determination. Aboriginal Health Workers are constantly taken out of the decision making process by management, this leads to criticism from both the community and the staff of the health sector.

On Participant suggested:

"The staff were not prepared to listen to our way of doing things, sometimes when this happens you become physically, mentally and emotionally drained." (Participant Five)

By what my participants are saying is that non-Aboriginal colleagues and bosses are listening but not hearing, won't allow any autonomy and are then passing the buck back to the Aboriginal Health Worker because things are not working. These are issues that are causing Aboriginal Health Workers to burn out and leave their jobs. Will there ever be true self-determination and not just Rhetoric? So if there were generic job descriptions for each particular Aboriginal Health Worker area, (eg-Aboriginal Liaison Officers (in hospitals), Aboriginal Health Education Officers, Aboriginal Sexual Health Workers, Aboriginal Mental Health Workers, Aboriginal Drug and Alcohol Workers, etc.) a lot of the problems described in this chapter could be alleviated. The next chapter discusses the present lack of recognition and status of Aboriginal Health Workers and how the participants see these difficulties affecting their work.
CHAPTER FOUR
The Recognition (& Status) of Aboriginal Health Workers.

There are a number of professional programs and courses specifically designed for Aboriginal people supposedly to empower them in the helping professions and there are numerous mainstream courses undertaken by Aboriginal Health Workers. However, immaterial to the qualifications held by an Aboriginal Health Worker, the status of the Aboriginal Health Worker remains very low within the health arena, Aboriginal Health Workers have no voice in any decision making and are not treated as professionals. How has this lack of professional recognition of Aboriginal Health Workers impacted on their self-esteem?

I would like to begin this section with comments by Ian Anderson (1993)

"Good outcomes are possible, and this will depend on the relationship between the doctor and patient, the strategy of care from the doctor must be economically, socially possible, and desirable. This can be difficult enough when doctors and patients share a class and cultural background. You can imagine how much more it would be difficult it is if the advice is being given by a member of a colonizing culture to a member of a colonized one."

p. 38

There is little or no recognition for Aboriginal Health Workers. There is no trust for Koori Health Workers from the non-Aboriginal professionals; this appears to be due to racial stereotypes of Koori people. These stereotypes include ‘Aboriginal people are uneducated;’ ‘Aboriginal people are violent;’ etc. These are the types of things that you are forced to listen
to all the time. It is these stereotypes which prevent Aboriginal Health Workers from gaining professional recognition. This is the theme that will be explored in more detail in the Results section.

Anderson shows clearly the value of Aboriginal Health Workers and their liaison role between two such people.

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For Aboriginal health to improve health systems need to be ‘fair dinkum’ about what Government Departments say they will do. Since the Alma Ata conference declaration of 1978 stated:

"The conference strongly reaffirms that health, which is a state of complete, physical, mental and social wellbeing and not merely an absence of disease, is a fundamental human right and that the attainment of the highest possible level of health is the most important worldwide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector." (WHO, 1998, p2)
These comments are what underpins the reason Aboriginal Health Workers are essential to the health of Aboriginal people. This rhetoric has been repeated many times. Why then are Aboriginal Health Workers still struggling for recognition.

In 1978 Lak Lak Yunupingu a senior Aboriginal Health Worker from Yirrikala, in Arnhemland, stated at the 1st National Aboriginal Health Workers Conference in Darwin:

"Will Europeans accept everyone to be trained as one? Don't leave Aboriginals low and others high. Will our general training levels be high enough for Health Workers training and for other types of training?" (p9)

The participants were frustrated that nothing had changed. Each of the five participants in this research, indicated their feelings and frustration in the job that they had once been employed in. The confusion and frustration of not being recognised as a health professional caused great concern, the lack of trust from other work colleagues, the huge expectations from their bosses, and the high levels of stress that goes with the job.

The confusion about the definition of the role of the Aboriginal Health Worker has somewhat caused stress related illness to the worker by being unemployed. The lack of an agreed Health Workers role and the lack of a professional recognition is a major area of concern for Aboriginal Health Workers, Trengza and Abbott’s (1995) comments again repeat what the Health Workers have been saying for sometime. They (the interviewed participants) pointed out that many of the positive images created by rhetoric and theories do not exist in reality.
This lack of uniformity of the role, and recognition and status of Aboriginal Health Workers will continue to cause them problems. If we take Anderson's comments into consideration then so will the health status of the Aboriginal community fail to improve. This lack of recognition shows the structural racism of other health professionals towards Health Workers.

Cyril Coaby (1984) spoke about some of the different pressures and problems faced by Aboriginal Health Workers:

"The work of an Aboriginal Health Worker are subjected to different pressures in their work and community life, which is defined as cultural stress, ie living and working in the same community but applying western ways of caring for people and going against cultural ways. This is extremely difficult. Most of the time an Aboriginal Health Worker lives in the community where they work and quite often their work, and private life is intertwined with the community in which they live. They share the same burdens of illness, crisis's, as the community people. Aboriginal Health Workers are still expected to participate in the life and activities of the community in which they live or other communities in which other family members may lives. One important community activity is to attend funerals, which is a common Aboriginal practice and an expectation of the local Aboriginal Health Worker, especially if that person was a client of the Aboriginal Health Worker. This may include travelling for long distances for the family to take their loved one home, so not only do you attend that funeral as a mark of respect, you also attend because of your work, however a funeral will take priority over work commitments."

(p 3-9)

This quote from Coaby's article, although lengthy, describes precisely not only the problems I have been describing about living and working in the same community for Aboriginal Health Workers, but also the cultural difficulties faced by Aboriginal Health Workers working in mainstream environment where cultural obligations are not considered.
The failure to recognise these issues is all the more difficult to accept when we consider the words of one of the participants who spoke about never being offered any kind of assistance. One participant commented that if they had been informed of the Departmental Policies such as, stress leave, bereavement leave, family leave, sick leave and parenting leave etc, they may have been encouraged to stay. On occasions the Human Resource Units of Hospitals and Organisations have made the worker feel as though they were doing them a favor. The Human Resource Manager still wants the worker to look up to them as a good boss or colleague, to establish their territorial grounds, to use the power of the superior person and gain the Aboriginal persons trust. The worker feels that after they have begun to trust the manager they are then stabbed in the back, and talked about, behind closed doors.

I was recently listening to a woman talking during lunch about how she had been a Aboriginal Health Worker for twelve years and she is having a difficult time having to fight for some back money that is owing to her. Her main concern was the possible chance of being pressured too much about her fight for her money and she felt she would have to leave her position. This money owing to her is only money that is rightfully hers from all the national pay increase for all workers each year.

How can this happen when the pay increase was for the entire public sector. She should not have to fight for something that is rightfully hers. The saddest thing is that the people involved with her are not supportive at all. They have said to her, “I will do this, I will do that—all these favors
for you and your still complain!". It appears that this is precisely their job and they should not treat it as a favour.

As an Aboriginal person with an enrolled nurse background and ten years working as an Aboriginal Health Worker with the Health Service, I had always felt that my frontline manager has never recognised the full potential of the Aboriginal Health Workers. Their experiences as workers, community members, the status that the person may hold in that particular community was not given due credit.

Delegates at the 1997 National Aboriginal Health Workers Conference support my argument with the statement below:

“The overall status of Health Workers has not changed over the years at all. Their career structures and potential for professional development are limited. Delegates expressed their frustration at a lack of clear definition of the role of Aboriginal Health Workers, this causes confusion and high expectations of what is required of the Aboriginal Health Worker by both the community and by employers and colleagues and leads to high levels of stress, issues of miscommunications and poor retention rate.” (p.86)

Encouraging mainstream services to give health back to Aboriginal people was adopted by the New South Wales health system but to date this policy has not put this into practice. Aboriginal people in New South Wales need to have significant control over their health for it to improve and not just saying it. We have our medical services to take control of our own health however the limited funds from government is making it a slow process of delivery of health service appropriately to the community. Aboriginal people have been disadvantaged in not making
decisions about their health and is taken out of their hands by the structural power of the invaders (Anderson, 1993).

Anderson writes that the invaders perspective is too narrow minded to address all health concerns that have resulted from colonisation. The western model of management has been imposed on the traditional dreaming model of management and this has resulted in Aboriginal people being ignored and blamed for their present health status.

The failure of area health services and staff to acknowledge Aboriginal Health Workers as health professionals in their right usually leads to forced resignations and burnout due to the high expectations from the health system and community people. Gaining recognition as health professional has been a constant battle for Aboriginal Health Workers in NSW. Regardless of the persistent lobbying of Aboriginal Health Workers to have their voice heard on this issue at local, State and National levels, these health systems still refuse to recognise the skills that the Aboriginal Health Workers already have to deal with the community and their problems.

The National Aboriginal health strategy (1989) states that:

"Until tertiary institutions recognize the need for and benefits of culturally appropriate, relevant academic content and clinical experience for all health professionals there will continue to be difficulties in attracting and retaining health professionals to work amongst Aboriginal communities and a limited understanding of Aboriginal health issues."

59
As the Strategy suggests graduates must walk away with degrees that mean something in the workforce that they may be employed in. If we consider the actions of the New South Wales Health in refusing to acknowledge these qualifications within the career structure the question must be asked are the Aboriginal Health Workers wasting their time. The recognition of Aboriginal Health Worker’s will continue to be limited in the mainstream services while ever Aboriginal people come under non-Aboriginal managers and not having any form of management structure in place that suits the Aboriginal person. These management issues are often overlooked with many practical things also overlooked, which make the job run more smoothly. For Aboriginal people small things often mean a lot:

- The location of their office;
- Who they work with;
- Not having a good chair to sit on can be detrimental to the Aboriginal Health Worker, this is a basic piece of equipment can creates huge implications;
- Having to beg, borrow or steal basic stationary and office equipment; and
- always being questioned about their work.

One participant commented:

"In my 9 months of employment I was shifted 5 times, and anyone and everyone had the authority to do move me. On one occasion I shared my office with Winnie the Pooh, EE-Or the donkey, Humphrey B Bear, rattles, building blocks,"
etc. This location was actually the toy storeroom. But when they shifted me out to the back of the hospital that was even worse. They never give me any reason as to why they was shifting me they just done it. I was so isolated out there and there was times I just wanted a Koori person to be in hospital so I could go and yarn with them. I was really stressed when they put me out the back. I couldn’t see any of my people walking around, and when I got real stressed like that I couldn’t work properly. I couldn’t do anything! I didn’t like the isolation, then I started to realise I was just a token blackfella in here, and they wasn’t being honest about the Koori people.” (Participant Four)

Another participant became concerned over small issues;

“I never had any kind of administrative stuff, like pens, paper, computer, access to a fax, photo copier, I more or less had to beg to sections of the hospital for the use of these things.” (Participant Three)

Encouraging mainstream services to give health back to Aboriginal people was adopted by the New South Wales health system but to date this policy has not put this into practice. Aboriginal people in New South Wales need to have significant control over their health for it to improve and not just saying it. Aboriginal people have our medical services to take control of our own health however the limited funds from government is making it a slow process of delivery of health service appropriately to the community. Aboriginal people have been disadvantaged in not making decisions about their health and is taken out of their hands by the structural power of the invaders (Anderson, 1993).

The participants have indicated to me that impact of racism through the lack of recognition of Aboriginal Health Workers would have to be one of the most detrimental issues facing this group
of professionals. The failure of area health services and staff to acknowledge Aboriginal Health Workers as health professionals in their right usually leads to forced resignations and burnout due to the high expectations from the health system and community people. Gaining recognition as health professional has been a constant battle for Aboriginal Health Workers in NSW. Regardless of the persistent lobbying of Aboriginal Health Workers to have their voice heard on this issue at local, State and National levels, these health systems still refuse to recognise the skills that the Aboriginal Health Workers already have to deal with the community and their problems.

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As the Strategy suggests graduates must walk away with degrees that mean something in the workforce that they may be employed in. If we consider the actions of the New South Wales Health in refusing to acknowledge these qualifications within the career structure the question must be asked are the Aboriginal Health Workers wasting their time.

"Despite many attempts from Health Workers in New South Wales, the battle for clear role definition and recognition of their professional status, which would give Aboriginal Health Workers a say in management, little has been achieved in terms of implementation."

(NSW Aboriginal Health Workers Conference, 1998 p30)
The implementation of this policy remains largely the rhetoric while the traditional medical power structure are unwilling to relinquish control of health back to the Aboriginal people. This is a perfect example of organisational horizontal violence out of control.

Barbara Flick, (1997) highlights these issues with the following comments:

"Aboriginal Health Workers should receive the same level of recognition and reward then that enjoyed by the broader field of health professionals. This includes pay and working conditions commensurate with work and responsibilities. The author notes that these things are seen as generous gifts from the system by non-Aboriginal Health Workers and managers rather than a matter of fact and necessary adjacent to the work of the Aboriginal Health Workers as they should be." (p32)

The battle for role clarification and professional recognition goes back to the first National Health Workers Conference held in Darwin in 1978, then to the second National Aboriginal Health Workers Conference held in Sydney in 1997. Both of these conferences earmarked the Role and Recognition of Aboriginal Health Workers as a major issue for the future of Aboriginal Health Workers.

The Second National Aboriginal and Torres Strait Islander Health Workers Conference report contains the history of all Health Workers and their concerns, it clearly identifies the current funding system and resources allocations by the government. This document contains the historical background of the previous national Health Workers conference. Doing this research has given me the opportunity to actually see if there has been any kind of change, if there is, it is too small to measure. It is obvious that the role and the name of the Aboriginal Health Worker
has changed somewhat over the years from being nurses aides, nurse aid training, camp aides, hospital orderlies, and have in many places have different names attached to their position, for example HIV/Aids, sexual health worker, drug and alcohol worker, diabetes education workers, environmental health workers, and their duties and responsibilities may be different in their workplace, settings and their conditions may vary.

One of the participants emphasised how a lack of recognition can effect Aboriginal Health Workers:

"I was expected to cover the whole hospital whilst a social worker was allotted to one wing of the hospital, with a big flash office. When I asked what was the reason for this I was told that the social workers had more experience than me and better qualifications. He only had a Diploma in Social Welfare—I had a degree and what about life experience—doesn’t that count for anything? So what they are saying is that a whitefella with a diploma is more important than a blackfella with a degree.” (Participant Two)

One of the participants gave some background information about their role:

"Realistically, an Aboriginal Health Worker works 24 hours a day. Too many non-Aboriginal middle managers obstruct Aboriginal Health Workers. They will not acknowledge us as professional people. Our qualifications still do not count for nothing. They seem to be ignored. Even though we have equal qualifications we still don’t get the recognition for our studies. We are drug & alcohol workers, social workers, interpreters, taxi drivers, counselors, babysitters, mediators, right in the middle of everything—damned if we do, damned if we don’t—but never recognised." (Participant One)

In 1985 accreditation of the first Aboriginal Health Workers registration board in the Northern Territory was completed in an act of Northern Territory Parliament this was the first of it’s kind. The Northern Territory remains the only place in Australia where Aboriginal Health Workers
have full professional recognition through an act in Parliament. This act is enacted under the Health Practitioners and Allied Professional Registration Act. (Gootjans and Spiers, 1997)

To become registered your only requirement is to have Basic Skills training (clinical), but the board also accepts equivalent certificates. However New South Wales graduates from universities still do not have any form of an association in place to protect these workers or registration supported by legislation. Also here in New South Wales the Aboriginal Health Workers act as:

- Cultural brokers;
- Interpreters;
- Social workers;
- Mediators; and
- Health care providers.

So what more do Aboriginal Health Workers need to do to become registered and recognized as professional and skilled people?

The National Aboriginal and Torres Straite Islander Competency Standards are a set of work related standards used for training of the Aboriginal Health Worker. They were developed through consultation with Aboriginal Health Workers throughout Australia by the National community services and Industry and Training Advisory Board. There are 68 units of competency.
ATSIC considers it to be essential that any national development in education, training and employment of Aboriginal Health Workers are flexible enough to accommodate local variations in needs and priorities. (Aboriginal Health Information Bulletin, no18 December, 1993)

Aboriginal Health Worker National Competency Standards attempt to provide a pathway for all workers that want to go in different directions. Maybe the complexity and diversity of roles that the competency standards describe is why we can’t get an Aboriginal Health Worker Association. The multiple pathways described is forcing us into diverse directions to be included in one association e.g., clinical, management and community development.

Participants have complained that the New South Wales Public Hospital Award seems to go against Aboriginal Health Workers who struggle to become skilled through education. Aboriginal Health Workers are confronted by the lack of recognition of their qualifications when after graduation they can still often be lower on the career structure than unqualified non-Aboriginal Health Workers. This is made even worse when people with qualifications that are not Aboriginal Health Worker qualifications are given preference and promotions before people with Aboriginal Health Worker qualifications.

Janice Reid and Peggy Trompf state;

‘Unless that training places more emphasis on the structural basis of Aboriginal health, and the social and cultural factors exacerbating health problems, incorporation of Aboriginal health professionals into health care services is thinly disguised assimilation’ (p409)
The absence of a clearly defined career structure for Aboriginal Health Workers has been widely criticised (Reid 1982; Thompson, 1984, Reid & Trompf 1991, Flick 1997, Jones 1998) and this has been exacerbated by the lack formal education and training received by many Health Workers.

The ability of Aboriginal Health Workers to organise to improve their status is inhibited because of their isolation, both within the state health systems in which they work, and in geographical terms. However, recognition of these problems is now more widespread and suggestions to improve career pathways based on length of service, supervisory responsibility, isolation, qualifications and administration responsibilities have been made.

This appears to be a form of horizontal violence against Aboriginal Health Workers if you have to get permission from the Chief Executive Officer of the Area Health Service to progress to a senior health worker stage when you have obtained your degree. One participant stated:

"What a bummer! You go to Uni studying full time for 4 years, with no experience and can become a Senior almost at once. You can have 20 years experience but without a diploma in education you're stuffed!!!!" (Participant Five)

An Aboriginal Health Workers education program began in 1984 at the Redfern Aboriginal Medical Service, after the realisation that the other systems of training were not appropriate for the Koori people and community. This program was headed up by founding member Sister Dulcie Fowlers, and has continued to enhance Aboriginal people into health positions. It seems
that the Aboriginal Medical Services have tried to work towards recognition of their Health Workers, while New South Wales Health Services appear unable to do this.

One of the participants responded,

'I have never been recognized as a professional person in the place in which I worked. The Gubba people are always checking and questioning you about your qualifications. Where you gained your certificates and what kind they were, and to see if they had any credit ability from which institutions. Even the staff in in-service training would ask about your qualifications, to see I suppose, if they need to believe in what you are saying. Being an Aboriginal Health Worker is being like a life sentence for something that you have done wrong because, your boss won't even see you worthy of anything, no career pathway etc. There is nothing. I mean nothing gives with the job, just racism you can walk away from the job with nothing—just a life time of abuse.' (Participant Three)

According to the NCSHITAB there is around 1300 Aboriginal and Torres Strait Islander Health Workers in the workforce (National Community Services and Health Industry Training Advisory Board, 1996 p25). The Aboriginal and Torres Strait Islander population according to the ABS the 1996 population of Aboriginal and Torres Strait Islander people in Australia was 319,003(ABS, 1996). So if we accept the ratio of Aboriginal Health Workers to population of one health worker to one hundred people as recommended by Trengeza and Abbott then just over 3,190 workers are needed, and therefore the shortfall of Aboriginal Health Workers of over 1,700. This is another example of the lack of recognition of Aboriginal Health Workers where a standard can not be accepted and adhered to. Westmead hospital has one identified Aboriginal Health Worker position to cover the whole complex. (Trengeza and Abbott, 1995)
The National Training and Employment Strategy, for Aboriginal and Torres Strait Islander Health Workers and professionals working in Aboriginal and Torres Strait Islander health has stated that:

"Lack of Recognition of Aboriginal and Torres Strait Islander Health Workers role means that:
1) There is no reliable data on the numbers needed in communities;
2) Training has been developed on an ad hoc basis, and does not reflect a set of recognized core skills which are transferable between states/territories or even regions;
3) Secure, ongoing funding for training has been difficult to access;
4) Wages and conditions vary markedly between states/territories;
5) Communities are not always aware of the range of skills; and
6) Other health professionals are always clear about their role and expertise. (1996 p25)

The National Training and Employment Strategy for Aboriginal and Torres Strait Islander Health Workers and professionals working in Aboriginal and Torres Strait Islander health goes on to suggest:

"Headway has been made towards the establishment of a national forum to enhance the worker with a feasibility study. This will no doubt strengthen the status and self esteem through collegial interaction. This forum will have the responsibility to:

1) Define the role of the Aboriginal Health Worker;
2) Taking into account the specialist area of substance misuse, environmental health hospital liaison etc;
3) Develop a model that suits both sides, Aboriginal health and mainstream health;
4) Develop a code of ethics for Aboriginal and Torres Strait Islander Health Workers and practitioners;
5) Check the parameters of legislation, which would facilitate the operation of Aboriginal and Torres Strait Islander Health Workers as both autonomous practitioners and multidisciplinary health care team members. (1996, P25)
CHAPTER FIVE
Racism (& Discrimination) against Aboriginal Health Workers

5.1 Racism

Aboriginal Health Workers are exposed to racism within the workplace routinely. Worse than not being recognised as a professional person, Aboriginal Health Workers are regularly subjected to scrutiny of their work and time to a much higher degree than other health workers. How has the Aboriginal Health Worker role been affected by Racism?

White Australians are not used to being racialised. Their colour and racism toward others is invisible to them, and in their daily lives they give little or no thought to the way that ‘Whiteness’ impacts on the lives of Aboriginal people. (McKay, 1999)

Lillian Holt, Director of the Centre for Indigenous Education at the University of Melbourne, a Murri woman from Cherbourg, takes the reader through humour from hilarity to hell and back to sobriety in her chapter, ‘Psssst ... I Wannabe White’ in Belinda MacKay’s 1999 book ‘Unmasking Whiteness: Race Relations and Reconciliation’. A long quote from Holt, but worth the read:

“But colour is not just skin deep as whiteness attests to. Whiteness shamed and whiteness blamed. It defined and it delineated. That is, it defined and delineated who could come into the fold and who stayed out. In the spectrum of blackness, whiteness divided and ruled and, as a young girl, I was too ‘boongie’ even for the local black beauty contests such as the Miss Opal contests. Whiteness saw to that for in the same way that little black girls chose white dolls over black ones, it too had permeated the psyche of the good coloured citizens who chose, consciously or unconsciously, the assimilated and acceptable face of lightness, so that none
of the winners were ever too ‘boongie’ looking. But while whiteness welcomed me, it also rejected me. That’s part of its paradox. Being able to drink of the same water but not from the same cup. And speaking of drinking, I was always ‘not like the rest of them’ (meaning my mob) whilst I was clean, sober and toiling, but when I got drunk, I was often just another ‘boozing boong’.

Naively, I dodged, ducked and rode the waves of whiteness which were ever present, thinking that there would be reprieve around the corner. Meanwhile, whitefellas kept on keeping on, glibly gliding through life, their superiority never allowing them to look at the shadow side — or should that be shallow side — of their inferiority. Finally I baulked. After endless years of aspiring, perspiring and desiring, I surrendered. The bereftness of whiteness had taken its toll on me. I’d played their game, with all its delusions and illusions. Despite being bright enough and light enough, I still was not right because ultimately, well, by now, it was pretty obvious ... I was not white.

I’d tapped on the brittle outer shell of whiteness and just when I thought it would open up a new world, it clamped shut like a clam shell. The marginalised are forever boundary riders when it comes to whiteness, or so I found.

My intuitive recall was alive as ever. From puberty to maturity, from schooldays to workdays, I knew for sure that whiteness was about apartness. Like a sensual, but slimy suitor, it had sucked me in then spat me out.

So, having generally located myself in relation to Whiteness and what it has done both for me and to me, why do you reckon I wannabe White? The answer is simple: to alleviate the pain of being the target of racism. I’ve tried everything else to shake off the racism which leaves scars on one’s soul. That racism which is about pigmentation and identification of you as ‘other’. That racism which has whitefellas in this country saying: ‘You’re imagining all of this, Lillian’. That white racism, which says: ‘You’ve got a chip on your shoulder, you’re too sensitive, too paranoid’.” (p 44-45)

As an Aboriginal person, I know Lillian Holt is not being too sensitive or paranoid and can report that Aboriginal people receive racism as part of our daily lives, we expect it shopping, we expect it in accessing services, in educational institutions and in our daily dealings with non-Aboriginal peoples. This is not to say that we condone these behaviours or accept them ‘as our lot’, but we do experience racism daily. However, when an Aboriginal person works for a Government department, where there are rules and legislation prohibiting racism and where you
could assume that the people you work with and for, are not only aware of these rules, but are better informed. However, this is not the case and whether the racism experienced is due to racial hatred, ignorance or a form of horizontal violence to ‘keep the natives in their place’—it is still offensive and cruel. You don’t ever become accustomed or hardened to these types of behaviours. It is possibly harder in the workplace to tolerate such behaviours because you accept the position believing that you will have some protection and that you may be able to make a difference for your own mob.

Aboriginal Health Workers positions are identified as “Aboriginal”, this immediately leads to racism against these workers. Claims of ‘you only got the job because you are black’ or ‘you don’t have to have the same qualifications as us’ are common. Even if you do have the same or better qualifications, well, ‘they must be lower than ours’.

What constitutes racism? Racism can both be overt and covert, it can be seen in both its forms to be part of wider range of dogmas often including such attendant “isms” as sexism or ethnocentrism. To address one without the other is to paint an incomplete picture.

Van den Berghe (in Stafford and Furze 1994; p. 14) Describes racism as any sets of organic genetically transmitted differences whether real or not, between human groups are intrinsically associated with the presence or absence of certain relevant abilities or characteristics. Hence, such differences are a legitimate basis of ambiguous distinctions retained by groups socially defined as races.
This is the sort of behaviours Aboriginal people wake up to each day, this type of behaviour often goes unrecognised, but can drain the Aboriginal Health Worker both mentally and physically and causes a high incidence of burn out. This also leads to Aboriginal people being destructive to one another—turning the frustrations inwardly (horizontal violence).

Janice Reid and Peggy Trompf suggest from The Royal Commission Into Aboriginal Deaths in Custody that:

"Being Aboriginal it's self is a health hazard, regardless of the racial discrimination act of 1975, 'racism is well and ripe here in Australia. Much of the racist issues that came with the Europeans back in 1788, are still here today. Australians do not acknowledge that they have still have the same issues here in 1990's." (1989, p.9)

From one participant:

"Aboriginal people face racism when they access services and the barriers which was bought about by the invasion, and these racist attitudes stop Aboriginal people from using the services they would rather lose a part of their body then be faced with racism and discrimination, one of my clients has lost his eye because he didn't want to tolerate the racism again like when he first presented to the hospital. These attitudes and this attitude of the staff you know stops Koori people from making any decisions about their life and stops them practicing their culture and spirituality, because all of these issues are connected like a complex web." (Participant Two)

Although many non-Aboriginal people contend that there is little racism in Australia, many Aboriginals experience Australian society as highly racist, whether they be children at school, people seeking accommodation, or employment, or people in contact with police officials. Non-Aboriginal people who lack knowledge of Aboriginal history and society are often to ask why
individual Aboriginals do not, in greater numbers pursue and achieve material success like many immigrants, some of whom come from disadvantaged backgrounds.

5.2 **Discrimination**

Discrimination is ‘The making of a difference in particular cases, as in a favor or against a person or thing unfairly’ or ‘treating a person or group differently than others because of their race, sex, age, religion, sexual preferences, disability or nationality.’ (Giddens, 1989, p224)

Discrimination literally means pre-judging by using stereotypes. In racial prejudice there is an assumption that all of a certain race will behave in a typical way of that particular race. When prejudice or discrimination is spoken about, --- racism etc, the very use of such terms evokes emotions. In fact, to my mind, the area of race relations is the most difficult and emotionally laden area of discrimination. There remains a need to define what is meant by the terms. There are dozens of definitions available and one could argue at length over the merits and disadvantages of their wordings.

Being accused of seeking isolation and stimulating racial hatreds is the anomaly of the proposal for Aboriginal autonomy. When it is actually the ruling class that has sought associations with overseas finance to sell our natural resources, the land for holiday resorts, etc. and industry to benefit a small group of the wealthy Australian business people. The fear that bestowing
autonomy to the first peoples of this land may lessen this power and wealth is the fundamental rationale of continuing ‘dependent autonomy’.

The abstract of the article, “Dependent Autonomy: A New Phase of Internal Colonialism” by Ian Hughes (1995), summaries the same anomaly from another angle:

“The history of colonialism in Australia is summarised into four phases, called external colonialism, internal colonialism, welfare colonialism and dependent autonomy. Four police frameworks for Aboriginal affairs:
1. subjection and exploitation
2. protection and segregation;
3. assimilation and integration and
4. self-determination and reconciliation;
coincide with these phases.
Contradictions arising from irreconcilable tendencies in liberal-humanist philosophy marked official discourses, practices and strategies during each phase of colonialism. Current policies are analysed in terms of political paradox. The self-determination policy, which promotes autonomy through increased dependency on the state, is analysed as a new phase of colonialism which is called ‘dependent autonomy’.” (p 186)

Autonomy is not a panacea or a formula for solving every problem. It is the beginning of a path: the basis for a strategy of participation, of development, and of struggle against exploitation and marginalisation. Autonomy could be the instrument to combat racism, still recognised as a huge problem in Aboriginal society and above all to recognise a fundamental right of all people: the right to free self-determination.

An evaluation of the Access and Equity Strategy by the Office of Multicultural Affairs in the Department of Prime Minister and Cabinet in 2000, found that Aboriginals experienced negative or discriminatory treatment from government agencies far more often than migrants. (2000, No. 75
According to the parliamentary inquiry report “Access and Equity: Rhetoric or Reality?”, the four principles underpinning the strategy for Aboriginal people, are equity, access, participation and equality:

- "Equity: ensuring that economic benefits are distributed equitably;"
- Access: ensuring that access to government programs is fair and equal;
- Participation: ensuring that all Australians have the opportunity to participate in personal development, community life and decision-making; and
- Equality: ensuring that everyone has the same civil, legal and industrial rights”. (p 14)

It is, however, problematic to imply that all of the experiences and aspirations of Aboriginal Health Workers are exhausted by the fact of racial subordination. As Paul Gilroy (1992) has argued, there is more to the emancipation of black people than opposition of racism. Simple anti-racism, which trivialises struggles against racism and isolates racism from other political antagonisms, fails to acknowledge the complex political forces from which racism emanates. The problem remains for Australia to develop more diverse and discriminating forms of analysis (Donald & Ratansi, 1992). However, in doing so, it is important to acknowledge that the process of establishing the primacy of forms of oppression (gender, race, class) is as much a political issue as it is a matter of diverse, critical analysis (Knowles & Mercer 1992).

The fact that there is more to the regeneration and legitimatising of the Aboriginal Health Workers worth, than simply eliminating racism is demonstrated in the next chapter in explaining and describing ‘horizontal violence’. Although some acts of ‘horizontal violence’ can be
CHAPTER SIX

*Horizontal violence*

6.1 *Workplace bullying*

Aboriginal Health Workers also face horizontal violence not only within their workplace to a higher degree than most other professionals, but they also face it within their own communities. Horizontal violence can take many forms and may be directed in particular against women and ethnic minorities or towards people because of their age, sexual orientation, physical or mental disability, or some other characteristic—eg being competent and popular. It may involve action, behaviour, comment or physical contact which is found objectionable or which causes offence; it can result in the recipient feeling threatened, humiliated or patronised, and it can create an intimidating environment. (Friere, 1978). How do Aboriginal Health Workers experience ‘horizontal violence’ and how much does this impact upon and effect their professional and personal lives?

*Bullying* is a silent epidemic that has been slow in gaining recognition as a significant workplace issue. It impacts on workplace efficiency and profitability and workers’ physical and mental health. Mistakenly thought of as something men do to subordinates, workplace bullying is neither solely a male preserve nor exclusively a behaviour practised by senior management. Co-workers commit *horizontal violence*, (Defined on page 66) students and juniors spread vicious rumours
and innuendo about their teachers and bosses. It is all forms of ‘workplace bullying’. All part of horizontal violence, aggression, bullying and harassment are increasingly common within the health service (Duffy, 1995).

The purpose of bullying is to hide inadequacy. Anyone, who chooses to bully, is thus admitting their inadequacy, and the extent to which a person bullies is a measure of their inadequacy. Bullies are people with impoverished social, interpersonal and behavioural skills who project their inadequacy on to others both to avoid facing up to and addressing their inadequacy, and to divert attention away from their inadequacy. In an insecure workplace, this is how inadequate and incompetent people keep their jobs (Duffy, 1995).

Contrary to popular belief, the average victim of a bully is a strong and skilled individual, as evidenced by the most common reasons for being picked on. Firstly, the individual is good at their job, often excelling, and popular with people. Envy (of abilities) and jealousy (of relationships) are strong motivators of bullying. Incidentally, bullying can be, but does not necessarily have to be a gender issue. Other reasons for triggering bullying include blowing the whistle (eg on malpractice, illegality; breaches of health and safety regulations etc.), standing up for a bullied colleague, or, more subtly, unwittingly highlighting or revealing the bully's incompetence simply by being competent. (Fanon, 1968)

6.2 Definitions

Workplace bullying comes in many guises ranging from subtle to obvious and general to selective. The bully can be a manager, a supervisor, a co-worker or a junior. Their behaviour
intimidates, degrades or humiliates an employee sometimes in the presence of co-workers and clients. It can include verbal abuse, behaviour which is intended to punish, constant unreasonable criticism, put-downs and sarcasm, poorly managed conflicts of opinion or personality clashes. Inappropriate comments about personal appearance or behaviour are common as are social isolation at work, overloading with work or under-utilisation of skills, exclusion from meetings and denial of job opportunities and promotions. In some cases, assault, either actual or threatened can be a factor. A definition of horizontal violence by Spring & Stern (1998) is:

"Harmful behaviour, via attitudes, actions, and other behaviours that are directed towards us by another colleague, horizontal violence controls, humiliates, denigrates or injures the dignity of another. Horizontal violence indicates a lack of mutual respect and value for the worth of the individual and denies other fundamental human rights" (p. 15)
Horizontal Violence

- Name Calling
- Power Games
- Limiting Free Speech
- Negative tone of voice
- Shared Remarks
- No mutual respect
- Talking behind back
- Devaluing qualifications
- Racial Slurs
- Insulting Dignity
- Judgmental Comments
- Intimidating Body Language

Figure Showing the Types of Horizontal Violence Identified by Respondents.
This figure shows the Violence moving inwards to the oppressed and outward to the less powerful.
Horizontal violence is recognisable, and definable, causes physical injury, hurt inflicted by another, and sometimes cannot be seen, however there is visible indicators that horizontal abuse goes also with horizontal violence. Horizontal violence, as described above, is a common occurrence with the health professionals, police officers, ambulance offices, and is a big threat to public servants in Australia. Horizontal violence and abuse is said to be rampant within the nursing profession (Spring & Stern, 1998).

Different research groups have chosen, in the English language, different terminology regarding destructive activities within workplaces. In England and Australia the word "workplace bullying" is preferred for this kind of behaviour. (Fanon, 1968, Duffy 1995, Spring & Stern 1998) A comparison of these two research areas exposes, in fact, quite different groups of hostile behaviour. Horizontal violence can be a type of ‘workplace bullying’, however horizontal violence can take place outside the workplace, is a common phenomenon in minority cultural groups and is more prone to be bestowed on persons from a minority group as a form of racial prejudice. (Fanon, 1968) My opinion is, that these two research areas should use different terminology because of these reasons. It would be very confusing to let ‘horizontal violence’ or ‘bullying’ be the chosen general term as these words really describe quite different social behaviours (Neuman, 1987).

6.3 Horizontal Violence and the Subordination of Aboriginal Health
6.3 Horizontal Violence and the Subordination of Aboriginal Health Workers

In the Introductory chapter the reader will see that I as an individual have experienced many difficulties at work. I had heard similar stories from other Aboriginal Health Workers I began to wonder if these problems were wide-spread. When I read the report, ‘Rhetoric and Reality’ from Tragenza & Abbott (1995), they confirmed that these difficulties I was experiencing were happening to other Aboriginal Health Workers in other places, outside my own arena.

As I searched for literature and spoke to co-workers about these issues, a few articles began to appear about ‘work place bullying’ and ‘horizontal violence’. This was an important finding as there were many similarities in what these authors described to my own experiences. The authors (Fanon 1952 & 1961, Duffy 1995, Riipenen 1997, Spring & Stern 1998, Richardson 1999) found that no one works at their best if they feel hurt, angry, vulnerable and powerless. Bullying can have a variety of physical and psychological effects on people. Commonly reported effects are:

- stress, anxiety and tension;
- feelings of social isolation at work;
- loss of confidence and self esteem;
- loss or deterioration of personal relationships;
- headaches, backaches, stomach cramps, depression; and
- deterioration of work performance

However my concern was that if these authors and I were right, then the experiences of
Aboriginal Health Workers was a problem but not uncommon because it can happen in groups of workers. However, the unusual situation of the Aboriginal Health Worker is in that we work and live in the same community and the ‘horizontal violence’ is not only experienced within the workplace, but also in our personal lives, within our own communities.

My search led me to explore the concept labelled ‘horizontal violence’. I began to discover a number of articles on horizontal violence. To my surprise a lot of these articles were written by or on behalf of nurses, who claimed to be the victims of oppression by doctors (Duffy, 1995 and Spring & Stern, 1998). I mention that I was surprised about this because from my experience it was the nurses and other health professionals, who in general are the oppressors of Aboriginal Health Workers. Having now gained a better and fuller understanding of horizontal violence, I can see that this is the oppressed becoming the oppressors—the cycle of turning the frustration inward on your own or someone that you see as ‘lower’ than yourself.

Many of the authors referenced Frantz Fanon as the person who first introduced the idea of horizontal violence. Fanon was an Algerian living in Paris studying to become a psychiatrist, who as a black man was on the receiving end of constant racist oppression. His first major work, ‘Black Skin, White Masks’ in 1952 had a major influence on civil rights, anti-colonial and black consciousness movements around the world. Fanon argued that white colonialism imposed and existentially false and degrading existence upon its black victims to the extent that it demanded their conformity to its distorted values. In this book he also demonstrates how the problem of race and of skin colour connects with a whole range of words and images, starting from the
symbol of the dark side of the soul. "Is not whiteness in symbols always ascribed to Justice, Truth and Virginity?" (Fanon, 1952 p. 27)

Fanon's book 'The Wretched of the Earth' in 1961, became a benchmark for oppressed people all around the world. Fanon began to speak of not only the 'inferiority complex' of oppressed people placed there by colonisation which results into bitter frustration and is turned inward, toward 'their own kind', but also the same inferiority complex felt by the oppressors—the very reason they had to be oppressors, the very reason they have to be the bullies at work. It is from his descriptions of this inferiority complex that horizontal violence originated. (Fanon, 1961)

Duffy (1995) and others have used Fanon's ideas to explain the process of horizontal violence. Nurses according to Duffy see themselves as an oppressed group and at the lower end of the health hierarchy. Nurses claim to be oppressed by other health professionals for two reasons. The first is that nursing is predominantly a female profession, the oppression in this instance emanates from the patriarchal nature of medicine. Oppression for nurses also occurs because nursing has only recently defined itself as professional and has not had as long to build up its status within other health professional groups. (Duffy, 1995)

Oppression is the key element of horizontal violence. Oppression focuses on a single group for particular characteristics common to that group. As I have stated, for nurses these characteristics are that nursing is a female profession and newly recognised as a 'profession'. Horizontal violence is multi faceted and a direct cause from continued oppression.
The oppression of horizontal violence has common characteristics when it confronts the individuals in groups. During interaction between oppressed groups and oppressors the characteristics of communication takes the shape of a derogatory tone of voice of oppressor to oppressed, body language which displays arrogance or lack of interest, attitudes which make people feel inferior and judgmental replies which stereotype oppressed group ideas as not as good. This interaction on occasions leads to more extreme relations such as talking back angrily, slurred remarks and humiliation, which appear to the oppressed groups as the only available response to oppression.

Groups known to them to be oppressors often manage the oppressed groups, which leads to a professional inferiority. In the case of nurses they are often in subordinate positions to doctors. When decisions are made nurse’s feel they are not given a fair hearing. Nurses also describe the glass ceiling for promotion and feel that no matter what achievements they make that they can not progress beyond this ceiling. This also occurs for Aboriginal Health Workers. This means that incomes remain overall at a lower level then the incomes of the oppressing groups.

Fanon states.

"The colonised is elevated above his jungle status in proportion to his adoption of the mother country’s cultural standards." Fanon 1961. p18

Fanon is saying that the whiter you act the better you are accepted by the oppressing group. Duffy also describes this within nursing when she suggests that it is the nurses who take on the characteristics of the oppressor who are best accepted by the oppressor, these people are then
promoted to senior positions. The grass roots nurses view these people as turncoats and traitors to nursing and are treated disparagingly by nurses. The grass roots nurses feel that the colonising group constantly gives the ‘whiter’ nurses these promotions as small favours. A comment from a nurse suggests:

“you have the confidence, but the system continually wears you down” (Duffy, 1995, p. 12)

Fanon (1961) and Duffy (1995) suggest that the effect of horizontal violence is often inflicted by members of the group against other members of the group. The sense of inferiority created by oppression leads to self destructive behaviors within the oppressed group. These behaviors limit the group’s progress towards a better future.
Horizontal Violence Against Aboriginal Health Workers: The Cause of Continued Oppression
The next step for me was to review the literature to find out whether what was happening to other Aboriginal Health Workers and myself could be viewed as horizontal violence. And again I was drawn to the work of Kathy Abbott, in particular a piece of work recently published in the Aboriginal and Islander health Worker Journal. Other excellent sources of data included both the 1997 & 1999 Aboriginal and Torres Strait Islander Health Worker Conference Reports.

The Aboriginal Health Worker profession is relatively very new, in fact much newer than the nursing profession. Aboriginal Health Workers are also predominantly female. These two features is the commonality between Aboriginal Health Workers and nurses. Two other factors stand out as differences between these two groups. The first is that we are Aboriginal people and as such face racism on a daily basis (Bullbeck, 1993; Hollinsworth, 1998 and Anderson, 1993). The second difference is that not only do we face ‘horizontal violence’ within the workplace, but also when we go home every day to our communities. It is well recognised that both Aboriginal men and women have a life expectancy of seventeen years less than those of the non-Aboriginal population of Australia (ABS. 1996), this is the most poignant indicator when we consider the end result of racism against Aboriginal people.

The point I would like to make here is that while Aboriginal Health Workers and nurses share certain characteristics, horizontal violence for Aboriginal Health Workers is likely to be far worse because of racism and the added burden of community ‘horizontal violence’.

Looking at the literature I also found Aboriginal Health Workers speaking about their education.
Some Aboriginal Health Workers do not attend Universities to become Aboriginal Health Workers. They gain their status as health workers from their life experiences. The oppressor (other health professionals) realise this and use it as a weapon to make these people feel inferior. The oppressor claims that their education and length of experience is superior to that of Aboriginal Health Workers. However, even if the Aboriginal Health Worker has a University education, other health professionals disregard this fact because ‘it is only a blackfella course’ or ‘it must have been a mickey-mouse course’, etc.

The 1999 Aboriginal and Torres Strait Islander Health Worker Conference Report highlighted the lack of support from the workplace and the lack of postgraduate programs for Aboriginal Health Workers as key issues for concern.

This concern shows that there are unequal education opportunities between other health professionals and Aboriginal Health Workers. This stems from the fact that still today only 15% of Aboriginal people make it to Year 12 in high school compared to 75% of non-Aboriginal people (ABS.1996). So, that from the very outset Aboriginal Health Workers are playing catch up in their education and often returning to University at a mature age students, trying to gain even the most basic qualification. Again other health professionals use this inequality to proclaim an inferiority of Aboriginal Health Workers.

The professional status of Aboriginal Health Workers is another major issue for Health Workers (3rd National Aboriginal and Torres Strait Islander Health Worker Conference Report). Shayne
Williams, a speaker at the conference, stated:

"I feel that Indigenous Health Workers have a long way to go" (Williams, 1997 Conference Report).

Aboriginal Health Workers need to work to raise the status of Aboriginal Health Workers (Flick, 1995). Aboriginal Health Workers are constantly reminded about who is the boss and the decision making power held by other health professionals in the health care system over Aboriginal Health Workers. Aboriginal Health Workers feel that they are at the bottom of the health system ladder. Other professions in the health care system such as doctors, nurses and social workers act as both professional opponents and oppressors, which keep Aboriginal Health Workers in this perceived inferior position. This creates a glass ceiling for Aboriginal Health Workers, which Duffy (1995) described as being an issue for nurses.

As well, Aboriginal Health Workers suffer criticism from their communities, Abbott states, "She's walking around with them doctors, she must be one of them" (Ellis, 2000, p. 4). This, I feel, is a shared experience of many Aboriginal Health Workers. This experience places us in a position of professional inferiority and cultural inferiority from the community. Aboriginal Health Workers feel as though they are caught in a vice getting pressure from all sides.

Generally, Health professional staff do not consider that Aboriginal Health Workers have the ability and education to practice autonomously. This acts as a self-fulfilling prophecy blocking Aboriginal Health Workers from making decisions. There seems to be no possibility for change for Aboriginal Health Workers to be nudged even just a little from their current oppression by
all sides. Our wealth of knowledge is not recognised, so they will continue to be trapped in a cellular embryo and not be able to grow as a profession. Kathy Abbott, at the Third National Aboriginal and Torres Strait Islander Health Worker Conference (1999) stated:

“...there is a process of negotiation and consultation within communities, that can only be carried out by Aboriginal Health Workers. There is, however, still no formal recognition of the actual workload that Aboriginal Health Workers carry beyond the primary health care role. Community and family obligations go far beyond the service that hospital and clinic provide; yet the Health Workers as cultural broker, family member, community member and worker must meet them.” (Abbott, Conference Report)

And, just as in nursing, the situation for Aboriginal Health Workers is that there are high levels of burnout, absenteeism, chronic illnesses related to stress and early resignations from their careers (Flick, 1995). These commonalities, the anecdotal evidence gathered at interview and my own experience confirms that Aboriginal Health Workers are suffering from horizontal violence.

Common themes and sites for this behaviour; physical maltreatment in the psyche arena, can occur without a component of physical violence. This type of violence is also difficult to measure, because it is much harder to see the wounds. This behaviour is designed to humiliate, degrade, and injure the dignity and worth of the individual, and towards one another. With Aboriginal people it is too often under identified and tolerated. This issue transcends the personal and has become widespread and institutionalized in some places.
Aboriginal Health Workers on a daily basis face these behaviours. They are constantly questioned, being pressured from both internally by employers and externally by the community.

I believe it is horizontal violence and racist attitudes, which cause the Aboriginal Health Worker to quit the profession. The workplace bullying towards Aboriginal Health Workers, as described in the Forward of this thesis and occurred to me in my first year of work, always appears to be hidden.

Targets of horizontal violence report stress-related health problems including high blood pressure, nightmares and sleeplessness, eating disorders, nervous conditions, depression - even suicide attempts and a deterioration in personal relationships. Horizontal violence can result in the victim either removing themselves physically from the workplace (sick leave, stress leave, resignation) or psychological withdrawal (avoiding involvement). The loss of self-esteem associated with constant criticism and bullying leads to poor performance, poor morale and low staff retention rates all of which are costly. The bad publicity generated by the cases that reach the courts or the press is also expensive for the organisation and damaging to professions (Fanon 1952 & 1961, Duffy 1995, Riipenen 1997, Spring & Stern 1998, Richardson 1999).

Unfortunately, sometimes workplace horizontal violence is hard to deal with under existing laws. However, where horizontal violence involves sexual harassment or discrimination on the basis of disability, gender, sexuality, race or age, a claim can be made under the Anti-Discrimination Act. The Occupational Health and Safety Act requires employers to ensure the physical and psychological health, safety and welfare of all employees and can also be used to protect the
targets of horizontal violence. Where horizontal violence involves physical assault or the threat of assault, the incident becomes a police matter. For Aboriginal Health Workers, the double jeopardy is that although these laws are in place to protect them, they are normally so disempowered and disillusioned by these behaviours not only in the workplace but also from the Aboriginal community in which they work and live that there is not the preparedness, formal expression or strength to carry through with the complaint system.

In their article, ‘The Johari Window and the Dark Side of Organisations’ Dr. Stewart Hase, Alan Davies and Bob Dick explains through a modified form of the Johari Window (Lutz, 1969) to describe aspects of the dark side of organisations and as a way of bringing them to life for would-be players in ‘corporate games’. The Johari Window has been around for some time and has often been used as a means to describing some of the vagaries of human communication and behaviour. This article describes a reconceptualisation of the Johari Window that might have some utility in understanding some of the darker aspects of organisational behaviour. The article presents the revised window and shows the dark side of organisations is a phenomenon rarely dealt with in management training programs and spoken of only in whispers in corporate tea rooms. Conspiracies of silence, collusion, ‘jobs for the boys’, hidden agendas and collusion are just some of the issues that affect the quality of working life of individuals and the effectiveness of organisations.

Hase et al, advocate that managers must be accountable for horizontal violence and workplace bullying behaviours at work because of the enormous price paid by individuals and organisations.
both in dollar terms and reputations. The authors show that prevention is possible, and essential, if an employer is to avoid liability for harassment, discrimination and workers compensation claims and the costs associated with high staff turnover, absenteeism, poor morale and poor productivity. Like many other human resource management issues and OHS risks, failing to deal with bullying unnecessarily reduces organisational efficiency.

Horizontal violence has been defined being destructive towards another person and as behaviour that humiliates, degrades, or otherwise indicates a lack of respect for the dignity and worth of an individual. This is very evident in most public sector workplaces where so few Aboriginal women gain promotions into top management positions, compared to Aboriginal men. Aboriginal men within these organisations and within Aboriginal communities punish, by ridicule, exclusion, or ostracism, any Aboriginal woman (Horizontal Violence!) who assumes the rights to interpret her own role or, worst of all, the right to rewrite the script.

6.4 Gender issues in Horizontal Violence

The symbolic devaluing of women became one of the founding metaphors of Western civilisation. The other founding metaphor is supplied by Aristotelian philosophy which assumes as a given that women are incomplete and damaged human beings of an entirely different order than men. It is with the creation of these two metaphorical constructs, which are built into the very foundations of the symbol system of Western civilisation, that the subordination of women comes to be seen as ‘natural’, hence it becomes invisible. It is this, which finally established patriarchy firmly as an actuality and as an ideology in Western society.
The contradiction between women's centrality and active role in creating society and their Westernised marginality in the meaning-giving process of interpretation and explanation has been a dynamic force, causing women to struggle against their condition. When, in that process of struggle, at certain historic moments, the contradictions in their relationship to society and to historical process are brought into the consciousness of women, they are then correctly perceived and named as deprivations that women share as a group. This coming-into-consciousness of women becomes the dialectical force moving them into action to change their condition and to enter a new relationship to male-dominated society.

For Aboriginal women, traditionally food gathering demanded elaborate knowledge of the ecology, of plants and trees and roots, their properties as food and as medicine. They were described as guardians of the fire, as the inventor of medicine, woven vessels and the holder of the secret knowledge. Woman knew how to transform the raw materials and dead animals into nurturing products. Her skills must have been as manifold as those of man and certainly as essential. Her knowledge was perhaps greater or at least as great as his; it is easy to imagine that it would have seemed to her quite sufficient. In the development of ritual and rites, of music, dance and song, she had as much of a part as he did. And yet she must have known herself responsible of live-giving and nurturing. Aboriginal women were man's equal and may well have felt herself to be his superior. (Broome, 1982)

Blurring of gender roles for Aboriginal women has created many problems in that this blurring forces Aboriginal woman to take on roles they may not be culturally comfortable with. The
pressures too, for example, adopt a feminist agenda and become a form of horizontal violence.

Western society has little girls playing games associated with growing up to be mothers whilst boys play games associated with firemen, train drivers and rough and tumble. In Australia, this form of colonisation of gender roles has destroyed Aboriginal kinship, tribal roles and law, the very spirituality of the people, the environment and the existing living habits. In post-invasion Aboriginal communities, women have a lower ranking then men, which leads to women having more restricted opportunities for social interaction. Inferiority of social position is manifested in the things that women do. "They are less valued than men are; this was done because of the prejudices of the invaders of this country". (Furz & Stafford, 1994, p243).

It has taken considerable time for the Aboriginal women to understand that getting ‘equal’ parts will not make them equal, as long as the shape of characters, the props, the stage setting, and the direction are firmly held by men. When women begin to realise that and cluster together between the acts, or even during the performance, to discuss what to do about it, this play comes to an end.

Giddens (1989, p.224) states that for a long time, studies of stratification were gender-blind in that they were undertaken and written as though women did not exist. Perhaps the fact that men undertook such studies may have had something to do with it!

Horizontal violence, racist behaviors and gender harassment are all forms of discriminatory
behaviors which can include a wide range of conduct and causes another person to feel offended, humiliated, intimidated, insulted or ridiculed. It is behaviors that are unwelcome, unreciprocated, uninvited and usually, but not always, repeated. These behaviors may cause damaging stereotypes to be maintained and is a breach of proper standards of conduct and professional behavior and are the exertion of power by one person over another person. They can be based in misunderstanding, but are usually deliberate acts and often contains a subjective perspective.
CHAPTER SEVEN
Conclusions of the Research.

The value of this research includes that it describes the horizontal violence that impacts on the lives of Aboriginal Health Workers. It attempts to give a voice to people who so willingly shared their stories with me.

What was most evident from the interviewees was the shame and emotional pain experienced by them as representatives of both their communities and the health system. The shame and pain were noticeable from what they said and in their faces. They were never encouraged to have a mentor or provided with support. It is this support and mentoring that their traditional kinship system is based on for Aboriginal people and gives them that which they were most familiar. It was non-existent in their jobs. This was reinforced when all commented about the loneliness and isolation when working as an Aboriginal Health Worker.

Their own communities placed expectations on them that are too high while, their superiors offered them no tangible support or encouragement to overcome this burden. Thus they could not complete their roles effectively. Finally the tension caused by the expectations from both their communities and their superiors became intolerable and all resigned their positions. Health services never saw the potential of these people, did not nurture them and so the Health Services lost a valuable resource when they departed. The interviewees repeatedly noted that management was completely impervious to the pain they endured, sometimes for years. The greatest difficulty recognized by the interviewees is Management's total lack of understanding.
of how Aboriginal culture and kinship operate and how the social worlds of the Koori communities are constructed.

The inception of Aboriginal Health Workers initially was that we were employed as assistants to "recognised" health professionals as a cultural broker between the community and mainstream health service professionals. Over the years the Aboriginal Health Worker role has evolved and now provides a comprehensive range of health services including clinical care, health education and promotion, drug and alcohol care, counselling, aged care and much more. The effectiveness of Aboriginal Health Workers is that they have an intimate knowledge of their community, know the people, their culture, customs and language and appreciate community dynamics.

However, our own communities have placed expectations on us that are too high while, our superiors have offered us no tangible support or encouragement to overcome this burden. Thus those that were interviewed felt that they could not complete their roles effectively. Finally the tension caused by the expectations from both their communities and their superiors became intolerable and all resigned their positions. Health services never saw the potential of these people, did not nurture them and so the Health Services lost a valuable resource when they departed. The interviewees repeatedly noted that management was completely impervious to the pain they endured, sometimes for years. The greatest difficulty recognized by the interviewees is Management's total lack of understanding of how Aboriginal culture and kinship operate and how the social worlds of the Aboriginal communities are constructed.

The Aboriginal Health Worker cannot function independently from these and will invariably
return to them if pressured by isolation and lack of recognition. Being an Aboriginal person myself, I share common cultural and working experiences with those I interviewed. I also share the same negative experiences of horizontal violence and discrimination. I feel that I was able to maintain my position because of my nursing background and working knowledge of the New South Wales health system. This was the key influence in my adjusting to the horizontal violence and bullying that is so prevalent in this environment. Unfortunately those I interviewed did not have the good fortune to have worked as a nurse, or have any other experience with the western Health System prior to being placed in their positions. They left their positions taking their pain and shame with them.

Horizontal violence is a direct cause of the lack of recognition and the management versus culture issues that face Aboriginal Heath Workers. In turn, the lack of recognition directly creates the situation where the role of the Aboriginal Health Worker remains diffuse and answerable to a multitude of management positions. Despite Area Health Services having signed partnership agreements with Aboriginal communities, the horizontal violence and bullying continues. It is expected that these agreements would protect the interests and well-being of Aboriginal Health Workers. The interviews reveal otherwise.

Behaviours need to change, in order that the individual Aboriginal Health Worker and the profession as a whole, may grow and take its place as a full member of the multidisciplinary health team. The behaviours of co-workers must change to respect, and the behaviours of Aboriginal Health Workers must change to self-respect.
Although this study has been largely exploratory in identifying issues of concern to Aboriginal Health Workers, it does not postulate any causal relationships between the various issues. This requires a further, more quantitative approach to draw any definitive conclusions about how the issues are related to one another. In this sense, the process is not yet finished. Future study should address how the shame and pain presently experienced by Aboriginal Health Worker can be isolated and minimised. Currently the future of Aboriginal Health Workers is not in their hands and formal, constructive discussion between Aboriginal Health Workers, their communities and management is urgently required to address these difficulties. This thesis does not pretend to offer solutions to these complex and troublesome issues. But it will hopefully focus the spotlight on them so that productive discussion can be initiated about the predicament of Aboriginal Health Workers and what can be currently done to alleviate the situation.
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