

**BLACKTOWN ABORIGINAL  
INJURY SURVEILLANCE  
AND  
PREVENTION PROJECT  
REPORT**

***UNITED WE WIN***

Cover illustration – Maureen Streeter

*“The design represents a map of Western Sydney, with a focus on Mt Druitt and key spots through to Westmead. The figures represent the fragmentation of the indigenous community, for although they live in the area their spirit has a longing connection to their homeland.*

*The different colour dots represent the many different clans living in the area, with the different size of red and coloured in yellow, while non-indigenous services are black and red. There are also yellow meeting places representing the desire of the indigenous community for change. Only a couple of the roads cross each other thus representing the services’ fear of loss of funding.”the dots representing the differing strength of the people. Aboriginal services are painted in black and*

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June 2003

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## **Blacktown LGA**

# **Aboriginal Injury Surveillance and Prevention Project Report**

### **UNITED WE WIN**

The glare of a thousand years is shed on the black man's wistful face,  
Fringe-dweller now on the edge of towns, one of a dying race;  
But he has no bitterness in his heart for the white man just the same;  
He knows he has white men friends today, he knows they are not to blame.  
Curse no more the nation's great, the glorious pioneers,  
Murderers honoured with fame and wealth, won of our blood and tears;  
Brood no more on the bloody past that is gone without regret,  
But look to the light of happier days that will shine for your children yet.  
For in spite of public apathy and the segregation pack,  
There is mateship now, and the good white hand stretched out to grip the black.  
He knows there are white men here today who will help us fight the past  
Till a world of workers from shore to shore as equals live at last.

**Oodgeroo Noonuccal (Kath Walker)**

Developed by the Aboriginal Community and local service providers

Supported by the Western Sydney Area Health Service

Funded by NSW Health Injury Prevention Policy Unit

## Acknowledgments

### Information providers

Many people have provided the information that describes the nature of Aboriginal injury in Western Sydney. Many groups provided formal data and assisted in unlocking its secrets:

Department of Education and Training, welfare services, employment and training providers, refuges, Aboriginal Liaison Officers, police, Aboriginal Legal Service, Aboriginal community Elders from Blacktown LGA, health care professionals, child-care services, emergency departments (ED).

Many others gave their time, valuable stories and understanding of complex issues of cause and effect. Many remain anonymous because their stories are personal and their privacy is important.

### Steering Committee

This report would not have been possible without the active participation and commitment of the Steering Committee. Their insights into issues and the networks that they shared are the foundation of both the process and recommendations:

Jamie Bellwood (Aboriginal Health Worker Mount Druitt Hospital), Kylie Parsons (Indigenous Community Development Worker, Blacktown Council), Yvonne To'a (Aboriginal Health Worker Blacktown Hospital), Anne Pont (ISU Manager, Centrelink), Eileen Hinton (ISU Centrelink), Daliah Fittler (ISU Centrelink), Maxine Conaty (ATSIC), Tabatha Timbrey-Cann (Aboriginal Specialist, Department of Housing).

### Project Team

Maureen Streeter, Aboriginal Injury Prevention Officer	Community networking, interviewing, project and report development
Jerry Moller, New Directions in Health and Safety	Project and report development and professional advice on data and injury issues.

### Western Sydney Area Health Service support

Christine Pollachini, Manager Injury Prevention  
Marie Wilson, Director Aboriginal Health  
Diana Aspinall, Safe Communities Project Officer  
Glenn Close, Director Epidemiology, Indicators, Research and Evaluation (EIRE)

## Executive Summary

As in much of the rest of Australia, routinely available health data are not adequate for detailed profiling of injury among Aboriginal people in Western Sydney. There are a number of factors that influence this. Many injuries are treated in settings that do not systematically report injury data. Data are only readily available from public Emergency Department (ED) systems and hospitals. Health data systems are known to have errors in identifying Aboriginality. Comparison of rates of hospital admissions with non-Aboriginal populations is also difficult due to problems with Aboriginal identification in the census data.

Emergency Department data comparisons were not attempted in this report because of the wide catchment area of the large ED departments and likely differential use of other treatment services for this level of injury. Many injuries appear to remain untreated.

Despite the fact that exact numbers and rates of injury cannot be determined, available data show that injury is a major problem in this Area. In particular, the level and nature of violence and self-harm is of concern. Cultural fragmentation, alienation and poverty appear to be major underlying factors. Unintentional injury is also common, with rates of injury increased by risk-taking, peer group pressure and hazardous environments.

Overall, the major features that need to be taken into consideration when planning injury prevention in Aboriginal communities are:

- the frequency, severity and causes of injury are poorly described and understood
- patterns of injury are closely associated with underlying social issues
- role models for children lead to high levels of risk-taking and injury
- peer pressure and status-seeking in a poor and alienated community results in severe injuries among adolescents and young adults
- intentional injury is of paramount concern
- violence is widespread
- self-harm is common and erodes the confidence of the community
- the threshold for treatment is high. Injuries are only treated when the injured person (or a relative) is convinced that it is safe to seek treatment or the injury is severe
- injury is accepted behaviour in the Aboriginal community. This includes both intentional and unintentional injury, and
- there is a lack of trusted, accepted and effective treatment facilities

Injury prevention programs cannot by themselves right the wrongs or take on the whole agenda on alienation and cultural erosion. They must, however recognise the importance of these issues and select priorities and intervention models that seek to redress the deep-seated distrust and anger in the community.

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## Abbreviations

LGA	Local Government Area
WSAHS	Western Sydney Area Health Service
EDIS	Emergency Department Injury Surveillance
AMS	Aboriginal Medical Service
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
Dharruk	Suburb of Blacktown
Daruk	Daruk Aboriginal Medical Service
ACCHS	Aboriginal Community Controlled Health Service
AHS	Area Health Service
ED	Emergency Department

## Aims of the report

- To describe injury among Aboriginal people in the Blacktown Local Government area
- To identify important issues and causes
- To identify possible ways of reducing injury
- To suggest priorities for action
- To stimulate a local Aboriginal injury prevention strategy
- To lay the foundation for reducing Aboriginal injury

## Background

The incidence, causes and impacts of injury among Aboriginal people tend to be poorly documented in Australia. New South Wales is no exception and a great deal of work has been undertaken to improve statistical information. Limitations in international coding standards mean that in-depth exploration of the high incidence of injury among Aboriginal people remains difficult. The NSW Health Injury Prevention Policy Unit has recognised this and has funded a number of Areas to utilise existing data and to undertake qualitative research to develop local information bases for understanding and responding to Aboriginal injury.

This report has been commissioned to extend the work already done in the Shoalhaven and Mid-North Coast Health Areas of New South Wales to an urban Area. The Blacktown Local Government Area (LGA) was chosen because it has a high proportion of Aboriginal people and the western suburbs of Sydney are the home to 7% of the NSW Aboriginal population.

## The Area

The Western Sydney Area Health Service comprises five Local Government Areas (Auburn, Baulkham Hills, Blacktown, Holroyd and Parramatta). This report will mainly consider the Blacktown LGA. This includes Mount Druitt, an area of high overall socio-economic disadvantage and a high proportion of single parent and low-income families.

The Aboriginal and Torres Strait Islander population for the Western Sydney AHS was 8,756 at the last census. This represented:

- 1.9% of the total population of the Western Sydney area
- 7.3% of the NSW Aboriginal and Torres Strait Islander population

Blacktown is the largest LGA in Western Sydney. At the 2001 Census the population was 256,364 (38% of WSAHS population). Injury within this LGA accounted for 24,5392-injury presentation in 2000-2001 (45% of Western Sydney Emergency Department injury presentations during 2000-2001<sup>1</sup>).

There are twenty-three suburbs within Blacktown LGA. Those showing significant socio-economic disadvantage include Bidwill, Blackett, Emerton, Lethbridge Park, Shalvey, Tregear, Whalan and Wilmot.<sup>2</sup>

Table 1 shows the distribution of the Aboriginal and Torres Strait Islander population within Blacktown LGA.

Table 1 Indigenous population in Blacktown LGA by selected suburb, 2001

	Indigenous population	Total population	Proportion
Bidwill	425	4577	9.3%
Blackett	246	3505	7.0%
Doonside	551	13719	4.0%
Emerton	106	2310	4.6%
Hebersham	271	5995	4.5%
Lethbridge Park	307	4869	6.3%
Mt Druitt	243	11612	2.1%
Shalvey	294	3758	7.8%
Tregear	316	3999	7.9%
Whalan	326	5871	5.6%
Wilmot	230	2540	9.1%
Dharruk	119	2873	4.1%
<b>Summary</b>			
WSAHS	8,756	682,397	1.3%
NSW	119,865	6,371,745	1.9%

Source: 2001 Census Data, CDATE 2001, ABS

The highest proportion of indigenous residents in the Blacktown LGA are children aged 0-4 years (18.3%), followed by 5-9 (16.5%) and 10-14 years (12.3%)<sup>2</sup>. Indigenous infant mortality is still three to five times higher than that for other Australian children.<sup>3</sup>

Since August 1987, the area has had an Aboriginal Community controlled health service. This is the Daruk Medical Service, which was initiated with Commonwealth funding<sup>4</sup>.

Blacktown LGA has high rates of reported crime compared to state averages, with seven out of eight categories significantly higher than the NSW rates. Blacktown has high rates of assault (12 per 1,000) and break and enter of a dwelling (16.1 per 1,000) compared to NSW (8.5 per 1,000 and 12.7 per 1,000 respectively)<sup>5</sup>.

Over one quarter of young people in the 15-19 years age group in Blacktown reported no income. Of those receiving a weekly income the highest proportion obtained \$40-\$79. The highest proportion of those aged 20-24 years received \$300-\$499 per week. The majority of people aged 55 years and over in Blacktown do not participate in the work force<sup>6</sup>.

## Key Priorities of the NSW Aboriginal Health Strategic Plan

The National Aboriginal Health Strategy 1989 recognised Aboriginal Community Controlled Health Services (ACCHS) as being the most efficient and effective way to deliver holistic primary health care to the Aboriginal community. This approach incorporates the principles of Aboriginal community control and cultural appropriateness. The principle of Aboriginal community control is also an integral part of the NSW Aboriginal Health Partnership.

The NSW Department of Health is committed to improving health outcomes for Aboriginal people through greater access to both mainstream and Aboriginal specific health and related programs.

Primary health care providers in NSW include ACCHSs, health services provided through the public health system and general practitioners (GPs). Studies reveal that while Aboriginal people underutilise public health and GP services their use of inpatient services is high. A range of issues impact on access to and utilisation of primary health care services, including distance, cost, lack of information and cultural insensitivity. In some regions, access to GPs who bulk bill is non-existent.

Improving access to health services involves effective networking within the partnership structure. The strategies in the plan are aimed at addressing the obstacles through a partnership approach. Consequently, responsibility for implementation of some of the strategies falls upon a range of service providers as well as the NSW Department of Health and Commonwealth Department of Health and Aged Care.

It is clear that health services have a leadership role in injury prevention. Many preventive strategies will, however be designed and implemented in other sectors because the root causes of the high levels of injury are found in the way in which society works and the social conflicts that have eroded Aboriginal well being over many generations.

## Sources of information

### Injury statistics and related data

#### Health data sources

Data on injury incidence is available from hospital-based treatment services (ED and inpatient) in Western Sydney. Other centres such as Daruk Aboriginal Medical Service community controlled (AMS); private polyclinics and general practitioners do not routinely keep statistics on injury presentations. Two sources of health system data have therefore been used in this report.

- Hospital separations data, which deal with all hospital admissions in NSW where the patient is resident in WSAHS.
- Emergency department data where the patient was treated in an emergency department within WSAHS. Data for the two years to June 30th 2001 were used in this report

While the study area is the Blacktown LGA, data are not confined to the residents of this area. Many residents of the Blacktown area use ED services outside this LGA. The data presented are thought to accurately reflect the mix of more severe injuries in the study area.

#### Hospital separations data

When a patient is admitted to hospital with an injury, information is kept on the external cause of the injury, the age and sex of the patient and their aboriginality. It has been demonstrated that Aboriginality of in-patients is under-reported. While programs to correct this are in place, it should be noted that because of the very large predominance of non-Aboriginal patients, even a small error rate can produce a significant underestimation of Aboriginal injury rates.

#### Emergency department data

Emergency department injury data are not as reliably or completely recorded as that for hospital admissions. It is therefore best used in a more descriptive manner. The ED data do, however contain text descriptions of the events leading to the injury and can therefore be a rich source of understanding of how injuries occur and possibly how they can be prevented.

The Emergency Department Information System (EDIS) in WSAHS was accessed to obtain data on ED presentations for the two years 1999-2000. A large number of cases were classified as injuries but had little information other than the age and sex of the patient. The EDIS injury data should include age and sex, external cause and intent. There is also a field for text description of how the injury occurred.

The high number of missing cases indicates that there might be other problems with the classification of the data. As this study is primarily concerned with injury to Aboriginal and Torres Strait Islander people, the text descriptions provided for these injuries were

checked against the coded cause and intent. The most important error found was the failure to code assaults even when the text included mention of an assault.

While there are errors in the data, it is still possible to undertake descriptive analyses. Unfortunately the catchment area of the EDs that collect the data is uncertain, as many people from other Areas use the services. It is not possible to calculate injury rates, nor is it possible to make comparisons of rates between Aboriginal and non-Aboriginal populations. Comparisons can, however be made of the relative importance of different causes of injury by comparing percentages of cause types in the two populations.

### **Police data**

Police data on attendances for violence in the Blacktown LGA for the period January to June 2002 were provided by the NSW Police Department as an additional source of information on violence, much of which is not treated in health facilities.

### **Interviews and focus groups**

Interviews were conducted with 42 key informants from agencies with an interest in Aboriginal well-being and members of the community nominated by the reference committee. From the initial interviews other contacts were identified and interviewed using a snowballing process. In addition as important issues were identified, interviews were conducted with key informants with specialist knowledge such as sexual assault, domestic violence, children's services and education.

Interviews were semi-structured, focusing mainly on the patterns of injury observed and possible causal and contributing factors. The style of interviewing encouraged respondents to identify and follow issues and ideas in addition to answering the questions (see Appendix). Each interview took up to two hours and extensive notes were taken. A typed summary for the use of the project was prepared for each interview.

Analyses identified the main themes and issues raised by respondents. Each transcript was then re-read to highlight and extract important quotes and to prepare summaries of each theme. The material in the report represents these summaries and direct quotes. The typed summaries and the text of the report were returned to informants for verification to ensure that the respondents saw the analysis as valid and that there was no concern that individuals could be identified. On some occasions where the text descriptions of injury events in the ED system or the literature provided clarifying information this has been noted to help validate the respondents' information.

While the key informants do not represent a random sample of Aboriginal people, they were chosen because of their knowledge of the local Aboriginal community and the issues they face. The majority of respondents were Aboriginal people. Their responses are likely to provide a valid and insightful picture of the issues. The information provided matches well with the detailed case descriptions gained from the ED data system and there was little inconsistency between respondents.

## Hospitalisation

### Overview

Figure 1 shows the mix of injury causes among Aboriginal and non-Aboriginal people in the Western Sydney Area. A mix of intentional and unintentional causes can be seen.

• Figure 1 Western Sydney Area injury hospitalised cases by major cause groups and Aboriginality

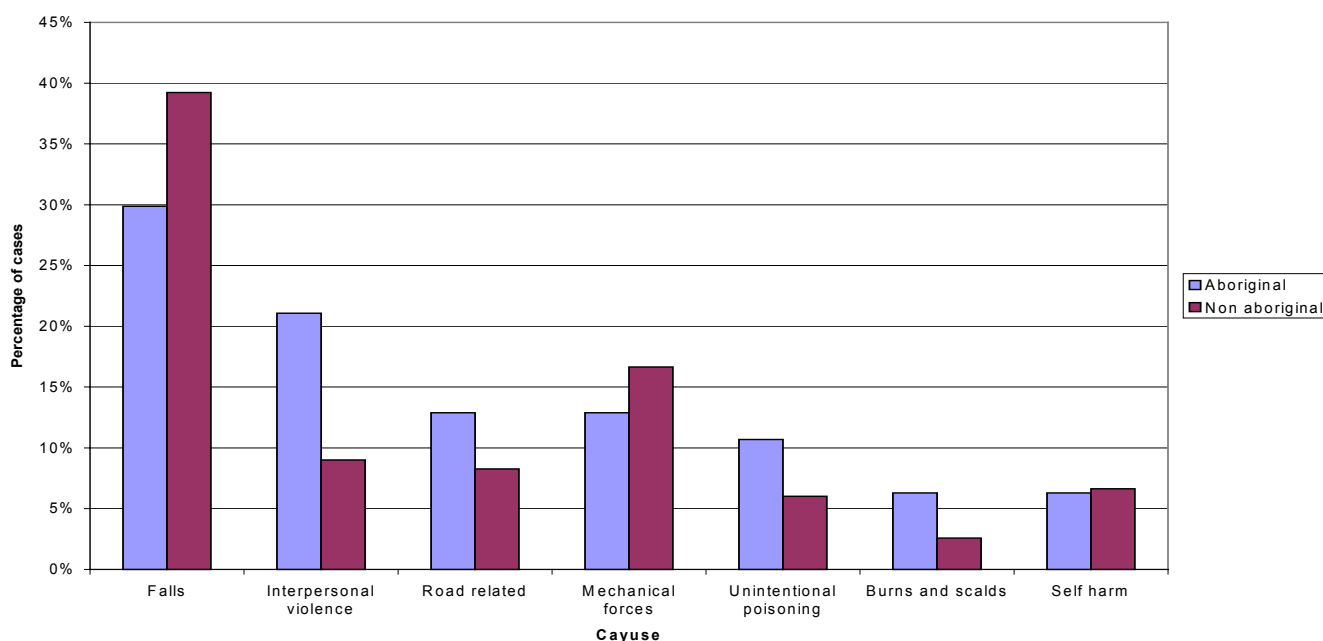


Table 2 compares rates of injury per 100,000 persons for Aboriginal and non-Aboriginal people. This should be treated with caution because there are difficulties in accurately identifying both the injury cases occurring to Aboriginal people and the local population through the Census. In the hospital data burns and scalds, interpersonal violence, unintentional poisoning and road related injuries had higher admission rates among Aboriginal people. When a correction was made for possible under identification<sup>a</sup>, rates of all external causes of injury were higher among Aboriginal people. The three-fold rate ratio estimated in Table 2 is in line with those reported nationally and in other local injury surveillance projects in NSW.

**Table 2 Summary of Injury Admissions by type of external Cause (excludes medical misadventure and late effects of injury)**

Cause	Number of admissions		Average annual rate/ per 100,000 persons		Rate ratio	Rate ratio Adjusted for likely under-identification of Aboriginality <sup>a</sup>
	Aboriginal	Non-Aboriginal	Aboriginal	Non-Aboriginal		
Road related	41	2013	235	152	1.5	3.1
Interpersonal violence	67	2193	384	166	2.3	3.9
Falls	95	9552	545	721	0.8	2.3
Burns and scalds	20	628	115	47	2.4	4.0
Self harm	20	1618	115	122	0.9	2.5
Unintentional poisoning	34	1468	195	111	1.8	3.3
Mechanical forces	41	4056	235	306	0.8	2.3
Other Causes		2822				
<b>TOTAL</b>	<b>318</b>	<b>24350</b>	<b>1824</b>	<b>1838</b>	<b>1.0</b>	<b>2.6</b>

Source: NSW ISC, EIRE 1999/2000

In assessing prevention strategies, seeing a difference in overall risk is not sufficient to plan interventions. Each of the major external causes were analysed by age group and sex to identify possible clusters of injury and differences in rates compared to non-Aboriginal people.

### **Burns and scalds**

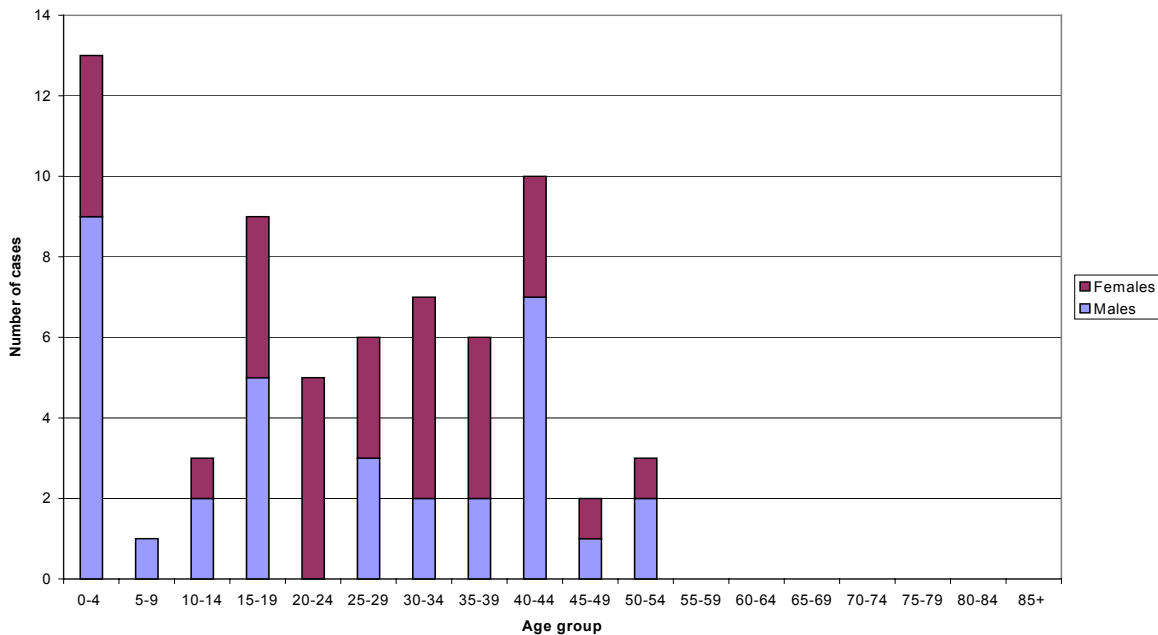
Burn and scald admissions were concentrated in the 0-4 age group. Risks in this age group were four to six times that of non-Aboriginal children with females experiencing slightly higher relative risks than males. Nineteen out of 20 admissions for burns and scalds were among children under five years of age.

### **Interpersonal violence**

The overall number of hospital admissions for violence among Aboriginal people is not large totalling 75 in one year. Violence occurs from the early years of life with rates of hospital admission among Aboriginal people consistently higher compared to non-Aboriginal populations. In the early years males had higher relative risks but in late teen and child-bearing years women were more commonly admitted. This suggests widespread violence where those who are weakest and most vulnerable are likely to be severely injured.

<sup>a</sup> Adjustment for under reporting is based on the assumption that 2% of the Non Aboriginal cases were in fact Aboriginals. This is considered a conservative approach as under identification of up to 7% has been noted in some studies

• Figure 2 Number of hospital admissions related to violence for Aboriginal people Western Sydney 2001-2002 by sex



### Poisoning and self harm

Hospital admission for unintentional poisoning is still relatively common and despite a decrease in fatalities, children under four years are at highest risk. This risk is between two and three times higher among Aboriginal compared to non-Aboriginal children. There was a tendency for females to have higher rates than males even at this age. Later in life teenage girls and young adult females (Aboriginal and non-Aboriginal) had increased hospitalisation rates, but the relative rates among Aboriginal women were three to five times that of non-Aboriginal women. Self-harm also rose sharply in these age groups with the relative risk for Aboriginal women being almost three times that of their counterparts. The agent in these poisoning and self-harm events was commonly prescribed and over the counter medications. This will be explored in more detail when emergency department presentations are considered.

### Falls and mechanical injuries

Almost one quarter of fall admissions among Aboriginal people, along with 20% of mechanical injuries involving inanimate objects, were in children under five years of age. The risk of fall injury was relatively equal among males and females in this age group, but males were more likely to be involved in other mechanical injuries. The relative risk for Indigenous people was approximately double that for non-Indigenous.

In older age groups the relative risk among Aboriginal people was similar to their non-Aboriginal counterparts. This may be influenced by different risk exposures. Work related injuries account for many of these events and differential access to work may reduce the risk to those who are unemployed.

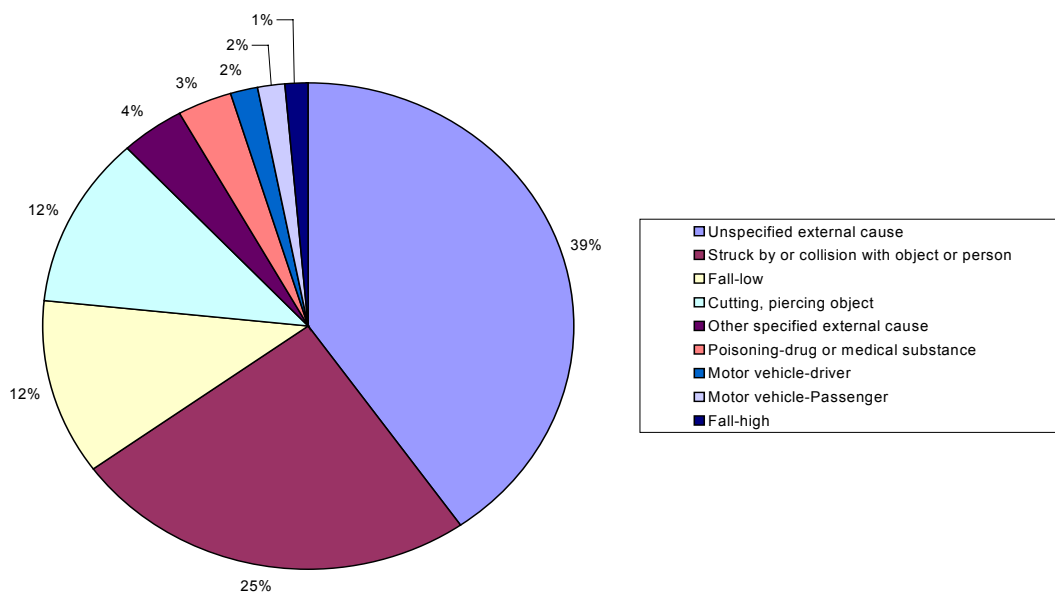
### Road related injury

Aboriginal people have an elevated risk (50-100%) of being injured on the road despite having lower access to motor vehicle travel. Examination of the types of road injury suggests that Aboriginal people were more likely to be injured as passengers of motor vehicles, as pedestrians or as young cyclists. This reflects different patterns of use of motor vehicle by Aboriginal people. They are less likely to be a sole occupant in a vehicle involved in a crash and more likely to be a pedestrian. Aboriginal children often start riding bicycles earlier than their non-Aboriginal counterparts and are more likely to ride without adult supervision and safety equipment at an earlier age.

### Emergency department presentations

Emergency department data were analysed to better understand age and sex specific injury patterns not requiring in-patient hospital treatment (Figure 3). Clearly there are many places where this sort of injury is treated, so ED data provide only a limited snapshot. For the purpose of these analyses Aboriginal and Torres Strait Islander people were grouped together as there were too few Torres Strait Islander cases to support a separate analysis.

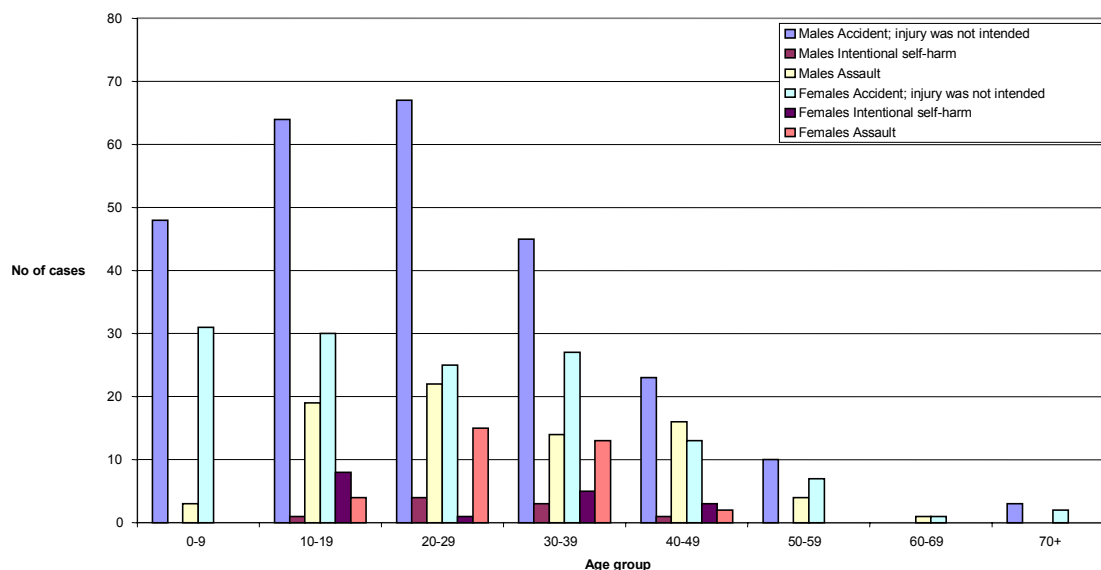
• Figure 3 Major Causes of injury to Aboriginal people Western Sydney Emergency Department presentation 2001-2002



Collisions between persons, falls, cutting and piercing injuries, poisoning and motor vehicle injuries are clearly an important source of injury for Aboriginal people. Many cases do not have coded causes and the codes used do not separate accidental and intentional injury. Cross tabulation with the intent code revealed that almost 35% of “struck by or collision with, object/person” were intentional however very few cutting and lacerating injuries were described as involving assault. Some however were linked to self-harming behaviour.

Figure 4 shows the age and sex distribution of assaults as coded by staff. Assaults were common among both men and women. The majority of assaults occur among teenagers and young adults but domestic violence accounts for additional injuries among women between 30 and 50 years of age.

• Figure 3 Age and sex distribution of cases coded by staff of ED as assaults Western Sydney 2001-2002



Examination of text descriptions showed that staff were reluctant to code assaults but mentioned them in descriptive data. Table 3 shows data where there was any evidence of assault in the ED record. Nineteen percent of injuries to Aboriginal males and 23% of injuries to Aboriginal females presenting to the ED (and were adequately coded) involved an assault.

**Table 3 Summary of intent from coded cases classified from text descriptions**

	Male		Female	
Unintentional or undetermined intent	293	78%	151	69%
Self Harm	9	2%	17	8%
Assault	73	19%	50	23%
<b>Total</b>	<b>375 (63%)</b>	<b>100%</b>	<b>218 (37%)</b>	<b>100%</b>

Source: NSW ISC, EIRE, 1999/2000

Text descriptions of injury events presenting to emergency departments were further analysed to determine detailed causes. The following summary is built from the combined in-patient and ED data including text description of ED cases:

- Violence is widespread with males featuring as both victims and assailants. Women and the vulnerable are more likely to present with severe injuries although this may be because males do not receive treatment even for quite major wounds. Violence is likely to be under reported in formal statistics due to reluctance by the patient to describe the cause and staff to code violence as a factor. Violence is involved in about one quarter of ED presentations
- Injuries to older people include falls, but violence may be a hidden contributing factor
- Alcohol is mentioned as a cause in most cases of violence
- Falls and mechanical injuries are often related to leisure and sports
- Poisoning is seen at all ages. Although numbers were small, medications used for treating mental illness, stress and anxiety were often identified as an agent. There seems to be a transition from accidental ingestion to over medication and overdose from childhood to adulthood. Self harm including self poisoning, self mutilation and neglect of personal safety and health are major contributors to Aboriginal injury
- Burns to children are not frequent but are important because of their severity. They often involve scalds or chemical burns with household agent, resulting in a large area of injury and long term treatment
- Motor vehicle related injuries include pedestrians, drivers and passengers. In addition to these traffic injuries, petrol burns are noted among young males and seem to be associated with the illegal use of motor vehicles or stealing of petrol.

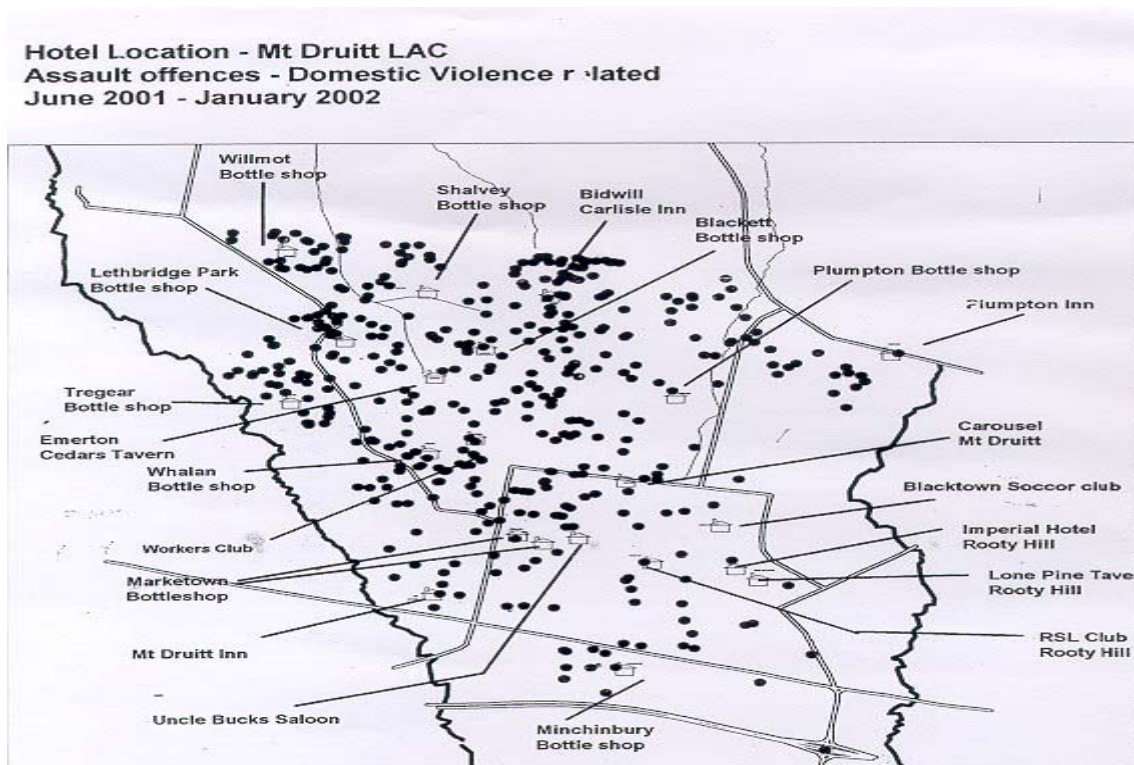
## **Police data**

Police data on domestic violence were examined. These were very detailed and included maps of police attendance.

Police data on attendances for domestic violence in the area show that:

- Violence is most prevalent in areas (open space and residences) close to licensed premises (this is perhaps not unexpected as these are also areas of higher population density and public activity that might be expected to have higher numbers of notifications). Figure 5 shows a map of the Mt Druiitt area with licensed premises and cases of domestic violence notified to police. These data cover all domestic violence notifications and are not limited to Aboriginal cases
- Between January and June 2002 domestic and family violence requiring Police intervention in Western Sydney accounted for over 5,000 incidents. The NSW Police Department regard this as an under estimate. The locations (and numbers of reports) events were Mt Druiitt (2118), Blacktown (945), Holroyd (601), Quakers Hill (583), Parramatta (499), The Hills region (343)<sup>7</sup>
- Some licensed premises feature more than others, suggesting that different management practices may be operating
- The alcohol effect is associated with both domestic or family violence and public violence. Assailants are most often males

- Figure 5. Mt Druitt Local Area Command police data showing hotel location and assault offences (domestic violence related) June 2001/02



### Crime and Violence

In NSW in 1999-2000, the most common causes of injury-related hospitalisation among indigenous people were interpersonal violence (19.9%), self-inflicted injury (8.8%), and transport accidents (6.5%)<sup>8</sup>.

Some episodes of violence are more obvious such as public fights. Family and domestic violence may be hard to detect as it does not always provide the obvious signs of physical abuse and family members may protect perpetrators<sup>9</sup>.

Aboriginal women:

- Were ten times more likely to be complainants in sexual assault hearings before the District Court
- Have particular needs in the court room and through the trial process that are different from non-Aboriginal women
- Were regularly asked questions about alcohol consumption, victims' compensation and promiscuity in order to challenge their credibility
- Seemed to experience greater distress during the court process
- Experience language barriers and problems with legal jargon that create particular difficulties

Aboriginal men were:

- 3.0 times more likely than the general population to be sexual assault offenders,
- 2.6 times more likely than non-Aboriginal men to be child sexual assault offenders, and Aboriginal men are 6.2 times more likely than non-Aboriginal men to be offenders of domestic violence<sup>10</sup>.

Perpetrators of violence are in many cases victims themselves, however they need to accept responsibility for what they have done and take steps to prevent it happening again otherwise the cycle of violence cannot be broken<sup>9</sup>.

## Information from interviews

This section of the report consists of direct quotations from interviewees that have been highlighted in grey. A summary at the end of each section consists of a collation of information from interviews and focus groups.

### **The definition of injury and the role of services**

#### **The scope and nature of injury**

#### *The voice of the interviewees*

“We really have to understand the underlying causes and the greatest contributor is grief. The level of grief experienced within the Aboriginal community is really distressing. There is great pain in it and nobody wants to hear that pain or feel it with the Aboriginal people. There is no respect, honour or compassion.”

Because of the historical legacy from loss and grief they are at risk of self-harm, domestic violence, violence to themselves and family. They are not injuries of the past; they are still injuries of the present day and will remain for generations to come. It can happen anytime. We need to look at why these injuries are still occurring and how can we change it. We can change it.

They have nowhere to go to get their needs met. There is no indigenous professional. Health workers do not have the knowledge of the issues. There would hardly be a day when someone who's brokenness doesn't come out about the colonisation of indigenous people. It's as plain as the nose on your face.”

“There were 2 Koori boys one white skinned, one really dark, picked up and the coppers took them to a certain room and belted up the whiter kid and told him not to hang around with the blacks.” “I have a friend. Her husband left her after 21 years and she took tablets and died. Another fella, his wife was killed in a car accident, he never used to drink but when that happened he became violent. Sadness seems to be the reason most people destroy themselves.”

“Aboriginal people have lost everything and survived marginally, but how much more can we lose without dire consequences. Something has to give and usually it's with the lives of our loved ones. The community can't help, they are in the same boat. They try and some get caught up in the circumstances and lose the battle themselves.”

### ***Summary and analysis***

Injury is not a clear and focussed concept in the minds of Aboriginal people in Western Sydney. Every interviewee mentioned violence, drugs and alcohol. Most mentioned many unintentional injuries and there was great concern about suicide. Intermixed with this were issues with broader implications that could increase the risk of injury. Gambling, poor nutrition, financial stress, poor housing and poor environment were all mentioned as linking to injuries. The Aboriginal people's view is holistic in line with the Aboriginal concept of health and wellbeing. Injury is not seen as a separate issue but part of an overall set of issues that erode the status and self esteem of Aboriginal people, their families and their communities.

Despite the lack of a clear definition of injury, there is clear concern about a number of specific injury issues. These are set out in the next section.

It is clear that the formal data severely underestimates injury incidence when compared with the Aboriginal community. Some Aboriginal people interviewed do not identify when presenting to hospital. This is often linked with a feeling that the injury or illness is not socially acceptable and may be related to victim blaming on the part of the worker.

### **Issues concerning services**

#### ***The voice of human service and health professionals***

"Injury has a huge impact on all those people, with people directly affected having visible signs or hidden ones. The strain on the community is fairly substantial because service providers would prefer to have no work that had self abuse or DV issues, rather than deal with them. It's a band-aid. We're not getting to the end result, getting back to our children by getting them back on track."

"Mainstream services discredit Aboriginal services and workers for what they do. They marginalise us even more if it justifies their existence. Is it going to be down the track that they don't need Aboriginal services, only Aboriginal workers in mainstream services?"

"Places like the hospitals. What I see they are still recycling those people, they are not empowering them so they don't come back again."

"The only time I see them is when they're in trouble."

"There is no culturally appropriate counselling. People who were forcibly removed as children experience loss and grief and separation which is still continuing today."

In reality Aboriginal people do not have access to professional counselling and we would like to know today after the National Inquiry why this is still occurring."

### ***Summary and analysis***

Professionals are seeing an increasing load of all types of need. Injury is just one issue among many. The problems are complex and deep-seated. The issues can't be separated. Feelings of anger and alienation arise from the "stolen generation" and poverty. The need is great but the level of service is low. Many people have given up using services that they need. They are often shuffled between services. They feel belittled, humiliated and not welcome. Generic services pass the buck to overwhelmed

and under-resourced Aboriginal workers in mainstream or Aboriginal services, many of whom are under-qualified.

The climate created is one of frustration amongst professionals and a feeling of shame at not being able to meet the need and make the much-needed difference. Inter-service relationships are strained as each service tries not to reveal to another service the problems and frustration that they are feeling, fearing that they will be criticised and their resources cut even further.

Many professionals feel that their agency's planning and resource structures are not flexible enough to permit all of the work to be done to make a breakthrough with their clients. Often job descriptions are tied to funding, preventing workers doing what is necessary. The result is a revolving door syndrome, where temporary partial solutions result in a return to a needy situation and a demand for yet more resources and services.

Workers often feel that they are there to fill a quota of Aboriginal service positions rather than being employed for their expertise as Aboriginal people and to make a difference. The focus is on process rather than the outcomes that the worker's desire...a better life for their people. This leads to a high level of burnout and conflict and lack of trust between agencies and workers. The workers and community feel let down and devalued.

Continuity of care is not available. People who have been on a long but steady road to recovery from difficult situations can one day find themselves isolated with no worker and no support. They can then rapidly turn and head backwards, increasing the future demand for services and eroding confidence in support systems and agencies. This erodes the self-esteem of the client, the worker and the agency.

Professionals are often frustrated at the lack of knowledge of the consequences of injury among their clients. In most disease fields there is widespread use of multi-media approaches but there is very little education on injury or the injury consequences of diseases like diabetes.

The "survivor" lifestyle of the Aboriginal Community involves being unemployed, living in Housing Commission housing, having at least three bills overdue and only being able to afford two dollars worth of chips for the evening meal. This is not uncommon for the Aboriginal Community in the Blacktown LGA. In this context, it is not hard to imagine why injury occurs, why nutrition is poor and the desire to escape through alcohol and other drugs is ever present.

### **Why Aboriginal people don't use services**

#### ***The voice of the interviewees***

"Quite a few don't go anywhere. Hospitals are just bad news amongst Aboriginal people. I've taken a number of our people to the hospital. Regardless of what people may say they are looked down upon. They read things into things that aren't there and they don't want to go back.."

"Non-Indigenous people would ring the police and report them to DOCS, whereas the Koori community would think twice about these measures because of the Stolen Generation and Black Deaths in Custody. They know they would get a serve from the police and get a good floggin'."

"She hurt her leg on a Wednesday; all the doctor did was strap it up. Nobody was taking her to the hospital till the next day. I told them to get her up there straight away."

"A lady came in, I think she was a DV victim. Her leg was cut to the bone. We tried to find out what happened but she wouldn't tell us. She might have been tied up with wire or something but she wouldn't tell us what happened. She was in her late 30's ,early 40's. She had 3 children. Stayed in a refuge about 6 weeks. That's the worst injury I have ever seen. She just packed up her things and left, she didn't say a thing."

"Some don't like "Service x" they say it's not confidential. Or they don't like who's working there. Factional things."

"I had a lady who rang me. Her three year old son had cut his arm on a fish tank. It fell on top of him and ripped his arm open. I went to his house. I had to call the ambulance. I told her I had to call DOCS; it's the law. She was so scared that she would have all of her children taken off her. Lucky I was there at the time; the child would have bled to death. She knows I would help her, that is why she called me. She had that trust for me. I stayed with her until it was all finished."

"First point of call is the GP and they refer them on. Some go to the AMS but it depends on the injury and how they got it. SHAME. He could have flogged me, I'm not goin to the AMS and say XXXX flogged me last night, let everybody know."

"A lot go to the hospital at the last minute. A lot wait till the AMS opens on Monday before they get treatment."

"There's too much favouritism with the Aboriginal community, they pick and choose who they want to fuss over."

"There are more people out there that need help and they don't like asking and when they're refused they won't ask again."

"Confidentially plays a big part in losing trust within the Aboriginal community."

"The welfare system has taken over our culture and that's our mentality now. There are no other avenues to go down. The family has broken down; there is no culture. There are all these groups out there and it's not working. It's our culture we've given up. The Community is doing their own thing. Organisations are getting greedier. There is no understanding any more. What is going on in our family unit? There is no community unit any more."

"I love my people. I want to see my people benefit. I've seen good people die and organisations getting greedier and greedier. It's never going to get any better until we get our culture back. I don't want us to get hurt any more. I want it to get better. I want us to go back to our culture and talk. Whatever, no matter what colour you are, we are all the same."

"The organisations in this area are jealous of each other. We have to work together."

"They've got no one else they can turn to but each other, Aboriginal families."

"I was told of a guy, him and another guy who was light skinned got a job together. The darker skinned man got all the shit jobs and ended up leaving after a short time. He went to another hospital and is doing all right there."

### **Summary and analysis**

Aboriginal people are avoiding contact with emergency health services when they are injured. They look for “black faces” ...friendly faces, with an understanding of culture and when an Aboriginal person in the area has an injury, they will only think of seeking treatment if the injury is very severe and they can be confident that there will be no undesirable consequences in seeking treatment.

Interviewees identified a fear of retribution from other Aboriginal people and even more fear that those who treat injuries will report incidents to the police, DOCS or Centrelink. This is especially important for children where treatment is often not sought for fear that the children will be taken away.

The participants identified mistrust of services, and concerns about confidentiality. Aboriginal people are suspicious that agencies pass information from one department to another, either formally or informally. Sometimes this occurs unintentionally. Just the mention of a name can identify a person and with additional information held in another agency, benefits can be stopped, people investigated and reputations eroded. The penalties in some agencies are so severe that the fear of even an unjustified investigation is enough to keep people from accessing needed services.

Confidentiality issues also arise informally. Aboriginal people are well known within Aboriginal communities (Koori grapevine). Even if a person is seen using a service or only passing by, rumours can arise about the reason and exaggeration often occurs. This is not conducive to seeking assistance and treatment.

There is also a strong feeling that some services are only for some people. Many interviewees indicated that there are cliques in the area and that benefits and services are only readily available to members or friends of a specific group. There are allegations of nepotism in some of the Indigenous services and a feeling that services do not trust each other or work well together. The community interviewed expressed their anger about this as it lowers their access to much needed services. They feel powerless to make any change but they want a united, open and accessible set of services that allocate resources and services transparently.

In this climate, agencies often find it hard to reach people in need. Agencies are less prepared to talk to each other and plan complementary activities. Communication between agencies becomes difficult and non-trusting. The agencies, like their clients, become the victims of a management and resource system that is not capable of responding effectively to the complex needs of Aboriginal people.

### **Violence**

#### ***The voice of the interviewees***

“A lady that had been bashed by her grand-daughter. She had a broken arm, lots of bruising and a lot of mental stress, not wanting to be there with her grand-daughter and not having anywhere to go so she had to stay there. Nobody did anything to try to get her moved either.”

“Another Koori lady had marks all over her body – cuts all up her arms. I think that was DV too. She had 3 children. She was moved on because her non-Aboriginal husband used to go around to the refuge all the time. She came from Taree originally, but he found out where she was. He tried to jump

through her bedroom window at the refuge window one night. A worker stopped him and called the police, but he'd run away by the time they had got there.

She used to suffer a lot, I think she had a mental illness, because she was always rousing, she was cranky all the time and swearing all the time and she was always in a deep depression. The kids used to play-up on her because she wasn't coping, but when her husband wasn't around she was a nice person.

The staff at the refuge were non-Aboriginal and just packed her stuff, took her and her 3 kids and dumped her on the Housing Commission. Now I hear she is back in Taree."

"There's one other form of injury, sexual abuse. It turns into physical. It's rife in our community, but no one wants to talk about it. The underlying factor to sexual abuse is substance abuse, otherwise it wouldn't happen to the majority. It has a big effect on the Aboriginal community because everybody knows each other, their family members, whatever. A sense of despair. There are people out there in the community that want to do something about it but they're family doesn't want to talk about it."

"Females are at higher risk – probably because of their fear of speaking up or resisting. Resisting the norm. It's not right for me to question where my husbands been after his been 3 hours at the pub."

"A young bloke in his 30's had a son to this other lady – she's now with his first cousin. Whenever he sees this woman with his cousin he asks how his son is and she tells him he is all right etc. But when they get home the cousin bashes her up for talking to him. He doesn't say anything in front of his cousin he waits until they get home and takes it out on her."

"Elder abuse really worries me because it's a secret silence like a sneaky little snake where people are manipulated for lots of reasons. A lot of it has to do with respect. Self respect as much as anything if you don't respect yourself how can you respect others."

"Because of the historical legacy from loss and grief they are at risk of self-harm. DV, violence, violence to themselves and family."

"They have nowhere for them to go to get their needs met. There is no Indigenous professional. Health workers do not have knowledge of the issues."

"They are not injuries of the past, they are injuries of the present day and will remain for generations to come. It can happen anytime."

"Sexual assault. I refer them to the AMS to the mental health worker, half the time they have been sent to me from probation and parole and it's not until I get to the underlying problem it will come out. You know if the parents are drinking and they have friends over and the friend wants to go to the toilet, they have to walk up the hallway and they see the boy or girl laying there in bed you know the rest."

"Helplessness in not knowing how to stop this violence. The family would think he's the biggest bastard under the sun. They would talk to him but they would hate him, everybody in the household would be terrified."

"The victim has no concern whose hurt out of this, they're not emotionally stable, they don't care or realise the effect on family members. They don't want to see who they're hurting. They're mental wrecks; they don't know what they're doing half the time."

“Violence oppresses the entire community because it impacts on the entire community and it holds us back from moving forward.”

“Men want to be dominant. They get a bit of piss in them. The more grog you drink the more it kills the brain cells, that’s why they feel good when they get a bit of piss in them.”

“Men I guess, the aggressive nature not only of the men but women. Independence makes them believe they can do it (violence) and what gives you the right to say they can’t - a bit of self-centredness.”

“For the victim it’s a lack of self-esteem that leads to self-destruction. Mental and emotional. And it has a big impact on the family. They suffer mental and emotional stress. For the community a lot depends on whether they know about it. If they know they will step in and support. A lot of the time they feel inadequate and hopeless.”

“Family violence is accepted and common. The woman working makes the man feel inadequate and forced into a role of DV out of frustration. You can’t just blame one aspect of it. You can’t blame one any more than the other nine out of ten couples who are victims or perpetrators of DV are going to get back together. You have to work in a holistic way all together the whole family to stop the cycle of violence.”

“The victims usually waits a few days for the bruising to go down before going to the doctor so they can tell the doctor a concocted story.”

### ***Summary and analysis***

Violence issues are often categorised according to the setting in which they occur (domestic, public, sport) or according to the victim (women, children, elderly) or the type of violence (sexual, physical, mental). These divisions often prevent a holistic consideration of the issue. In this area, all of these types of violence occur and all are important.

Violence is common among Aboriginal people in the area but great care should be taken to not blame the victims or vilify a culture. The level of violence demonstrated in this report has been identified as attributable to social and cultural stress and poverty. This is seen as a reason, not an excuse, and there is a strong desire for change. The questions of how to bring about change and where to find the resources are difficult for the Aboriginal people and services in the area.

Solutions to family violence that are limited to criminal sanctions and imprisonment of perpetrators are seen to do little to break the cycle of violence. There is a reluctance to report offences because there is a fear that imprisonment may lead to death in custody. There is also a belief that there are no effective programs in prisons that lead to rehabilitation and reduction in violence after release.

The literature and respondents agree that violence is never an acceptable method of solving conflict in relationships, nor do partners have a right to assault each other, whatever they may claim to have been the 'provocation'. Nobody asks for, or deserves to be, abused. The responsibility for the violent act rests entirely with the perpetrator but that the responsibility for a violent society lies with the whole of society.

A cycle of violence is demonstrated in the health data. Violence starts early in life. Many children are brought up seeing violence as a possible solution. Young males exhibit violent behaviour and young women exhibit victim behaviour as soon as they develop a notion of self. The basis of this is lack of self-esteem, a feeling of powerlessness and a lack of experience of success. This suggests a life-cycle, broad-spectrum approach to violence reduction rather than approaches dealing with segments of the problem separately.

## **Self harm**

### ***The voice of the interviewees***

“Yes self-harm is a big one, suicide. No they’re not like it all the time until it gets to a time when it takes over their lives.”

“A young person been away incarcerated, they come out healthy, well fed, nourished and then they begin to slide.”

“I don’t think they’re choosing to take their lives. Their relationship breaks down, they become transit, start to use drugs, don’t eat properly then they start to get other kinds of infections. One feeds the other.”

“If you sat them down at the beginning they’re not on self-destruct, they’re hopeful. They have to have opportunities and they have to be supported to take those opportunities.”

“There’s no forgiving of the Black kids. They’re blamed for everything. They’re not welcome into people’s homes, shopping centres or other places.”

No Aboriginal bus driver, shop assistant, policeman, solicitor, doctor. What messages are we given?

Go down to Emerton Shops and as soon as an Aboriginal person walks in security follows them.”

“It’s accelerating, the rate of incarceration. It’s a national disgrace as well as a community disgrace.

Given the level of marginalisation it’s amazing there isn’t more.”

“It affects the family mentally. They are affected by being depressed. If you’re likeable in the community, they might try to help and visit on a regular basis, have more visitors and have close friends stay with the victim, have people come around on a regular/daily basis.”

“They set out not to be deliberate but overdose because they want to feel better and then it turns out to be deliberate. No level-headed person sets out to harm himself or herself. If you weren’t a bit narrabung (not the full quid) you could.”

“We’ve moved away from our cultural beliefs. We need to move back to that. I feel that Western Medicine isn’t appropriate for us. Take for example a GP will see a Koori person and put them on Serepax. And then he is not taking our culture into account..”

“Yes some injuries are deliberate. A few would be slashing up, pills, hanging are the major ones. Probably after a fight or domestic dispute, and these things always seem to happen when Koori families get their wallen (money). Cause they’re full of soup (alcohol). D&A related, that’s only a result of the

D&A means of escape. Usually D&A injuries are where people are lamenting on what could have been and what usually is and they feel they have no control.

They vent their anger and it's a vicious cycle that they can't get a job and they can't remember the last time they had a job. It becomes a way of life which is passed on to the kids. Venting of above is a result of Housing, Health, Employment and the oppression of the Black man.

All of this has a devastating effect. You think people would sit up and take notice of what they're doing wrong for this to happen in their own family, and in the community but it doesn't make any difference at the end of the day because they're still stuck in the cycle."

"My girlfriend hung herself. And that is through DV. Nights and weekends at home. That's when people are drinking or have been drinking and taking drugs. That's when the carelessness starts, they get charged up and want to fight."

"You can't put your finger on one thing. It might start at neglect for a kid and when they're 18 it might end up with suicide."

"Adolescents/Youth – Drugs, gangs, the big thing suicide, you've got peer pressure. It's also important to remember Aboriginal kids have a hard time fitting in at any time and this is a time it's most difficult. It can make or break them in choosing their path.

I can remember Father Paul saying to me that they had something like 28 funerals in a space of 3 months. I've seen women come in that have lost not one but 2 sons by suicide and these are the sorts of things we have to deal with."

"The mother told me during one of my visits, that she had been hospitalised for self-mutilation. The mother, dad and one son and the girlfriend of the son were all doing it. They mainly cut themselves and burns. They were a pretty scary bunch. I didn't want to get involved. They had dreadful scars."

### ***Summary and analysis***

Self-harm can range from self-mutilation to overdosing and risk taking. The health data show only the tip of the iceberg.

Analysis of the interviews and emergency department case descriptions indicate that self-harm is quite frequent. The interviewees saw the impact of multiple suicides and repeated self harm on individuals, families and communities as wide reaching.

It is difficult, and possibly not important, to determine whether the people intended to kill themselves or were just trying to escape the pain of the current set of problems. Many events that appear to be self-neglect resulting in what appears to be unintentional injury are driven by feelings that there is no future and no chance of success.

The emergency department and hospitalisation data and incidents described by interviewee's show a pattern of overdosing and the use of psychoactive prescribed medications. Difficult situations are being treated with short-term consultations and pharmaceutical interventions that place not only the patient but also others in the family at increased risk. The interviewees were unanimous in their view that self-harm is related to alienation and loss of culture but that it is most often treated by Western medicine as a mental health problem of individuals.

Self-harm can erode the strength of the community. Those who are strong take on the burden but they too often become weakened by the load of caring for others. Services and programs available, appear to do little more than provide some support at a time of crisis. They do not provide the longer-term strategies needed to effectively manage the problem.

### **Poisoning and drug use**

#### ***The voice of the interviewees***

“I had a nephew, he was only a baby in a cot. His mother left him and his two year old sister at home alone while she went to a friends place for a beer. The sister found the mother’s iron tablets and gave the little boy a heap. He ended up in hospital for a while. He could have died.”

“I’ve lost 2 nephews recently, one 24 and one 29. They said he couldn’t cope, his partner said she heard a shout and found him in the shower. He died on the way to the hospital, a massive overdose. His body couldn’t handle it. The other one just got out of jail, the same thing. He hadn’t touched it for ages and then too heavy a dose.”

“My dealings with the teenager bracket. A lot are rebelling to a certain degree, a lot don’t have a home life. I can recall kids having gone home and there’s no food, there’s plenty of drugs. They feel it’s hopeless, a sad fact.

Even 8 or 9 year olds are on hard drugs. I know a 13 year old, he’s been on speed since he was 9.”

“Drugs, more so now. You only have to walk around Blacktown and see all the drug addicts going up or down from the methadone clinic and more and more Koori numbers are increasing. It never fails to shock me when I go around these streets. It’s very sad.”

“Aboriginal people are apprehensive about using medical services. Drugs, marijuana is a very depressive drug. A person can get so depressed they turn to violence.”

“A young girl was on drugs pretty bad. She ended up pregnant. Her mum didn’t know what to do. The girl went out to that GROW place (cultural camp) at Liverpool. I saw her after she had the baby. She looked dreadful.”

“Peer pressure, and like it or not kids are pretty cruel. They go to the ASPA classes and kids get into them. Getting into the habit of not going to school, taking risks like shop lifting, experimenting with drugs from glue sniffing to smoking marijuana.”

#### ***Summary and analysis***

Poisoning and drug use have been drawn together under one heading because when the statistics and the comments of the people and professionals are examined there is no clear boundary between the factors related to illicit drug use, over medication and accidental poisoning.

Poisoning occurs at all ages. The health data show that among young children it is mainly attributable to access to substances not stored safely including household cleaning and maintenance products.

For older children poisoning is related to the use or misuse of medication and this can merge in a seamless manner into patterns of drug taking and alcohol consumption during the early teenage years.

Underlying issues of alienation and poverty among Aboriginal people expose them to an increased risk of poisoning by exposing them to powerful and potentially highly toxic medications. Alcohol and other drugs are seen as an escape mechanism from the pain of daily life and loss of culture and meaning. Poisoning was seen by respondents as occurring because these substances are not used to treat the problem but to mask it.

The interviewees stated illicit drugs are used widely. Overdosing with prescription drugs, illicit drugs and alcohol either separately or together were seen as a feature of adolescent and young adult life, and as a way of escaping from unhappiness. They argued that acceptance by peers often involves showing that you are brave enough and rejecting enough of mainstream society to take illegal substances.

When this is added to a desire to escape from a raft of problems, the road to addiction and the criminality that addiction brings is a risk for a large number of young Aboriginal people in the area.

## **Alcohol**

### ***The voice of the interviewees***

“The community knows of a shop that opens at 8 a.m. to sell alcohol to children.”

“Particular days – pension days - they go to the tavern and sit in the park and have a few. Then it’s on for young and old.”

“Grief underlies everything: then they drink, they drive, they beat their wives up and that leads to depression.”

“If they’re drinking they may take something out of context and everybody’s in on it.”

“It’s from verbal conflict between people to 15/18-20 against each other.”

“You need to consider this is a public place, passers by might become involved, eg. a swing might be thrown and it might hit an innocent bystander. That’s assault involved now and the police are called.”

The attitude of some people is you see one drunk person they must be all like that. It’s not the case.”

“Alcohol abuse effects the community overall. The effect depends on the position they hold in the community.”

“There is a need for drug and alcohol awareness. Without being told the effects, they don’t know. It doesn’t matter. Stop the person from taking it.”

“Older people don’t tend to worry about wounds. We have older men affected with alcohol and they have vitamin deficient wounds and they let them go thinking they’ll fix themselves.”

“One old fellow, his daughter died. He keeps hitting the bottle all the time. He wants to die because of what happened to her.”

## **Summary and analysis**

Alcohol merits treatment as a separate issue because it has effects on so many other issues. The health data show that hospital treatment for acute alcohol poisoning is relatively rare but the role of alcohol in injury and the chronic effects are more difficult to tease out.

Information received through consultations/interviews indicates the effects of alcohol are widespread and serious.

Alcohol misuse is widespread and the effects of alcohol on health and its contribution to violence are very widespread. Alcohol contributes to many injuries on the sports field, on the road and at home and through violence in many settings.

While many Aboriginal people do not drink, many that do drink do so to excess. Those that sell alcohol accept the profits they make while criticising the violence/disease among those who purchase their product. Alcohol abuse by some groups in public settings portrays a negative image of the Aboriginal community and their culture and may influence false perceptions within the general community. One respondent described it as the 'ugly face of alcohol'.

The Western Sydney Alcohol and other Drug Action Plan has identified alcohol and other drug misuse as a priority for attention. The key population groups are young women, men, people with dual diagnosis, those exiting the criminal justice system and young homeless people. The plan states that this issue cannot be addressed in isolation and needs to be addressed in the context of the disadvantaged circumstances of the urban Aboriginal people<sup>11</sup>.

While Aboriginal people use alcohol to hide from their pain and non-Aboriginal alcohol vendors and licensing authorities place profit before health, the high rate of injury will continue. The alcohol problem is not just a problem of individuals who drink too much. It is a problem of a society that is too greedy to recognise and deal with the pain of Aboriginal people in an individualistic world and a foreign culture.

## **Leisure and sport**

### ***The voice of the interviewees***

"In heavy contact sport there is a lot of skin missing at the end of the game. Not all kids have the income to buy all the good/proper gear. If you already have a weakness there anyway it can add to the problem. Even the treatment after the injury, the player may need physio or a doctor and the parent or carer may not have the money".

"The bulk of injuries are from contact sports. There are injuries from netball, soccer, footy, even girls with touch footy. Sprains, jiggered up knees from netball."

"Injuries in sport are caused by not looking after themselves, putting themselves in dangerous positions, not thinking ahead of the outcome. Like when they cross the roads or climbing trees."

"Men – sporting, fighting amongst themselves, against peers."

"Sporting - lack of preparation. Coaches aren't trained as coaches but they're only doing the best they can. Clubs run on shoestring budgets. It's hard to keep committed people."

### ***Summary and analysis***

There are high levels of participation in sports and sports injuries are common. Many of these go untreated. Injury is covered up. It is considered 'weak' to show injury to the opposition and the scars of sporting war are seen as badges of honour. Sports participants, even children, become status producers for the community. Several interviewees stated that agendas move beyond the competition and often become grudge matches between old rivals. The traditional rival can be both Aboriginal and non-Aboriginal teams. Violence between spectators is common. There is either celebration or commiseration after a game. Alcohol flows freely both before and after games for the players and at all times for spectators.

For many, sport is not health producing and character strengthening. It is about trying to deal with low self-esteem and is linked to untreated injury, unhealthy use of alcohol and to violence and seen as a way of escaping their environment.

### **Risk groups**

#### **Children**

##### ***The voice of the interviewees***

"When I look at children that have suffered burns twice over I find that very distressing."

"There is a lot of abuse among children - mental and physical. If there is a really bad injury among children the family will take them away to hide it. Back to Bourke or somewhere."

"A lot of young people don't show up at hospitals because they have a record and they're fearful the gungies or DOC's will be bought in."

"Problems contribute to each other...bruising and malnutrition, the family is unaware of the foods they need to keep active and when they drink or drug they are not aware of the time to feed the kids. They are not aware of the basic requirements."

"Healthy eating is more expensive than non-healthy eating. Chips only cost \$2 where a health meal costs \$20."

"Kids around here play pretty rough, they play handball or netball and sometimes they get into a little biffo."

"There is nothing here – nothing for the kids."

"A lot of problems relate to emotional causes with DV, the children don't know what they're going home to. The partner doesn't know when to expect it or sometimes when they do they don't know how to prepare for it."

"I know of a 10 year old who still wets the bed. She is very anxious when voices are raised. The mother refuses to attend counselling to address the problem."

"There's no forgiving of the Black kids, they're blamed for everything; they're not welcome into people's homes, shopping centres or places."

“A young girl had an abortion one time, another might have had a curette. I get to the first home visit then they just ring me if they need me. If you tell them you need this or that they give up without trying.

I also see a lot of stress with women going into another relationship. The children are not his then they'll have children together then there's division in the family. You've got your children, which are not his, and his children.”

“Kids come in here with bruises and stuff. They're not going to tell you the truth, where they came from”.

“Children's accidents are from play, like cuts. Broken bottles and people drinking over there at Bidwell reserve. Most of our kids just play in the streets where they live.”

“A lack of appropriate play spaces. A lot of them just play in the street near their homes.”

“A lot of the kids suffer because they've got no home, they live in refuges and they're not very nice places to be.”

“The kids suffer because of family breakdowns and families because they don't have any family support.”

### ***Summary and analysis***

Both the literature and respondents argue that many types of injury among children are closely related to poverty, alienation and family and community dysfunction. Those interviewed, described a process of erosion of self-esteem from a young age, a battle with poverty and family violence, of role models that encourage aggression and neglect in times of stress.

Interviewees identified some play environments, e.g., local parks that have hazards not acceptable in other communities. Poor maintenance, rubbish, especially broken glass, and lack of facilities contribute to injury among children. At home, family disruption and lack of foresight of the needs of children and the need to protect them can result in serious injuries with long term consequences.

Injuries are often left untreated because parents fear that all bruising will be treated as a reason for investigation of abuse, leading to long and painful involvement with DOCS and perhaps the separation of the children.

### **Men**

#### ***The voice of the interviewees***

“A large proportion of Aboriginal men are in corrective services institutions and these men are missing, missing from family life, their life, their children's life and their community.”

“Women say I'm hurting, I better go to the doctor. Men are that macho stuff. I'm right and wait till it falls off.”

“Statistically, more Aboriginal women gain employment than Aboriginal men. Men are disempowered, they have limited opportunities. The only thing open to them is sport and socially, Aboriginal men are more likely primary care givers. The roles appear to be changing.”

“What I see with Aboriginal men is that they also need culturally appropriate counselling done by men. The legacy of removal has bought them into a time zone.”

“One of my guys was there when his mates mugged someone; he took off with his mates. While he was running he lost his wallet and was caught. He won’t give up his mates even though he’s been charged. He didn’t get injured. But this kid could have been injured.

There are a lot of things in place for women to be able to tap into services if they wish. There should be more places, more support services in place are needed for our men.”

“Men don’t show their emotions and speak about what’s bothering them as much as women will.”

“We should look at some of the issues of WHY men react and need to be at the Pub to speak to their mates, whereas women will pick up the phone and say hi I’m having a shit of a day blah, blah, blah.”

“I believe men are left out. Women are clever. They are in tune with their body. Men are at risk. They’ve lost their culture. They are scattered and don’t know which direction to go in.

Even though I am a man, it hurts to say that women look after themselves better.”

### ***Summary and analysis***

Injury surveillance data, across Australia and locally, show that injury is an important source of poor health for males.

Information from interviews and informal discussions with Aboriginal projects elsewhere in NSW, Western Australia and the Northern Territory indicate that the high rates of injury among men are seen as being determined by their position in society. Men are both the perpetrators and the victims of violence but the focus of programs is on their perpetrator role. Many of the injuries occur while men seek status and recognition from their peers and their partners.

Respondents advised that many Aboriginal males in the area suffer low self-esteem. Few have work and only rarely have positive status roles in Aboriginal society. Much of their burden of injury is related to status seeking, attempts to demonstrate power and a desire to escape the pain of being devalued.

## **Women**

### ***The voice of the interviewees***

“I reckon most women around here have been either sexually abused or raped. No wonder they are taking drugs and alcohol. I reckon they would have to be bashed up by their partners too.”

“I’ve seen many ladies come in here that have got no confidence whatsoever. That’s a big thing, looking for a job.”

“I know another lady she got a real lot of money from an accident that left her disabled. Her kids, most of them are my age, come and get hundreds off her all the time. Her daughter is working, she has a good job and wage, but she still comes and demands heaps of money from her. The mother gives it to her because she won’t see her children or grandchildren if she doesn’t. It’s the only time she does see them. Anything is better than nothing.”

### ***Summary and analysis***

Health and police data showed that injuries to women caused by violence are common, although under-identified in health collections. Women also harm themselves as they seek to escape the pain of difficult relationships and lack of family and community support.

Domestic and family violence is recognised as a very important issue and women seek the right to be safe with programs of support. These are important, however the picture painted by the interviewees suggests that for women to be safe, programs must focus on violence as a whole. It is important not just to focus on absence of violence and fear, but to build positive supportive relationships and families. The self-esteem of women is destroyed by violence and threats of violence and cannot be regenerated simply by short-term protection. The lack of self-esteem leads to difficult futures and often to a return to situations where the woman is abused yet again or decides that life is not worth living and suicide is attempted.

## **Social factors impacting on injury**

### **Social and environmental exclusion and alienation**

#### ***The voice of the interviewees***

“When I see a mother and child that hasn’t bonded then that’s an injury. It happened long before they come to the hospital. It happened a lifetime ago. It comes with removal of children, disruption of the family and family life, and it comes with long yearning to search for family members. And what I see, it’s that they’ve lost so much, they’ve lost their rights, their identity, language and culture. They’ve lost their family life, their childhood and freedom and their opportunity for education, justice and fairness. There seems to be a legacy remaining in which racism plays a big part.

When I see that kind of injury I see damaged families and I see low self-esteem. When they come to this hospital I see mistrust in agencies like ours because they see non-indigenous staff still in authority. Also, the injustice in coming to places like this hospital. They feel injustice is being committed again, again and again.

The non-indigenous staff are questioning them on their parenting skills and not enough respect is given to them as the mother and parent.”

“All the middle aged Aboriginal people belong to the population of people who were removed. They are affected by what has happened. There is no Aboriginal family that has not been affected by this. If we ask everybody to tell their stories, this is about the starting point of counselling. This is a starting point to tell their stories, in a crucial point in their lives, then you will find a larger population of people will be effected through removal. Employment; dealing with emotions, dealing with coping with changes that come.”

“The government is the main cause; because of many years of suppression and Aboriginal people having to fight tooth and nail for equality. It’s a vicious cycle, education problems, and employment problems, having to accept minimum and low skilled jobs, poor wages, not being able to provide quality of life for their families. Poor housing conditions as a result leading to poor health, low self- esteem, because of many years of being under the thumb, and obviously racism, and the problems relating to racism and the stereotyping of Aboriginal people.

The welfare mentality. The welfare gravy train and the Aboriginal people not being able to determine their own future continually hitched to government.”

“These are people who are having SHIT constantly kicked out of them. I think that loss of hope is most destructive. We see it in the young people in our community who are looking for a job and feel they will never get a job. They will say to you what’s the point.”

“When Aboriginal men were removed it seems like they were removed to an institution. There’s nowhere for them to go, to seek help, build self-esteem and they keep going back. Surely corrective services should have a culturally appropriate program to address their needs to go back to their families.”

“Go down to Emerton Shops and as soon as an Aboriginal person walks in security follows them.”

## **Poverty**

### ***The voice of the interviewees***

“In general the shopkeepers, keeping the bankbooks and locking the people into having to pay \$300 to that shopkeeper so they can’t go to Franklins for cheaper food.”

“At the interagency about 6 months ago it was documented one particular shopkeeper had 90 bankbooks. They were talking about doing a rescue package before they do anything about it.

They will deliver anything, milk, alcohol, meat (at inflated prices) and they charge an exorbitant amount”.

“Transportation out here is so pathetic. Grandmothers have five grandchildren in their care because the parents aren’t able to look after them for one reason or another. They have enough trouble getting around by themselves, let alone taking the shopping of five home. There are no resources and if there are, they are limited. The children are not respectful of the circumstances and society. People laugh about pension days – but that’s the only day when they are more mobile and they have the money to get around and take the shopping home in a taxi.”

“Elders, lack basic reading and writing skills. When they were younger they got away with it. Now this age of technology has made them very reliant on other people, which leaves them open for exploitation.”

“Key-cards are another problem. Some of them can’t remember their pin number so they give it to someone and when they go to get some money out there’s nothing left. That causes stress, then they ring us for some kind of emergency relief.”

“People are constantly in a state of crisis. Abuse, self-harm, crying out a lot of the time. They’re spending, scrounging, scavaging to survive.

They will share amongst themselves to survive.”

“Because we look after the kids, we have to take into account the families, extended families, and grandparents. Basically, their big issue is inability to access services to better their lives. A lot of that comes from a few issues and the biggest ones are housing, employment, education and health. Aboriginal people are behind the 8-ball in all these 4 areas.”

“Adolescents/Youth –there is a lack of resources for them. A lot of them spent their time at Mt Druitt shops; they hang around and get into trouble. Just the boredom leads to fights and all that. Even the local shops here but, we don’t have them now. The shopping centre closed down years ago the milk bar closed down recently, all we have left is the pub now. It’s a hassle for people, just for bread and milk they have to go to Blackett, Emerton or Hassell Grove.”

“Because we have a large population of diabetics, they have trauma to their feet. There are a lot of amputations because of this. Depression, manic depression and mental disorders also contribute to injury.”

“Neglect: dysfunctional families where the older children get stuck with their grandparents. Pawning the children and foster children off on to the grandparents. The parents are not taking responsibility for their own children. They are taken for granted physically, mentally and financially.”

“One lady I know who works at a nearby service, her children who are grown up go to her work every payday and take her keycard off her so they can get her money. She thinks that’s acceptable.”

“The elders are not looking after themselves because the family has left their kids with them. They don’t want the kids to miss out on a feed so they give everything to them and neglect themselves.” “We are forced to live this life style. It doesn’t work and I am really scared of what will happen to me as an elder.”

“They are not secure in housing, money goes on alcohol. They are in constant distress.”

“With Housing Commission they have Housing for Aboriginal homes, it’s supposed to better our people but it doesn’t. I’ve heard of people on syringes have been given 3 bedroom homes. They have no kids but get better assistance from the Housing Commission.”

### ***Summary and analysis***

Social and environmental factors shape injury risks, the number and type of injuries that occur and the development and access to injury prevention and treatment. Changing the frequency and severity of injury requires positive action to address its social causes.

The Aboriginal population in the area is drawn from a wide range of Aboriginal nations and traditions. Many are deeply affected by the disruption of European settlement and practices. In such a mixed Aboriginal community, establishing connections with culture and recovering identity is difficult. This in turn affects the harmony of the community and the individuals and families that comprise it. Injury rates are much higher and violence and self harm are key markers of social disruption in Indigenous communities across the world and the area in this study mirrors an experience well documented in all countries with Indigenous minorities.

Participants identified the following social factors that contribute to accidents, self-harm and violence.

- Cultural alienation and sadness and loss of self esteem
- Income and poverty
- Lack of access to employment
- Higher costs related to high levels of illness and poor transport

- Lack of environmental maintenance
- Paternalism and exploitation by shopkeepers

They also identified families and individuals who take on the role of helping others but noted that they too become overloaded and are placed at risk.

Those in need see the assistance given to others and make judgements about the fairness of the decisions. This in turn erodes the trust between the people, the workers and the agencies and continues a vicious cycle of need.

Injury prevention programs targeting specific types of injury, if successful, can contribute to building self-respect and may lead to confidence in dealing with other issues. Changing the frequency and severity of injury requires positive action to address its social causes.

## Principles for injury prevention

The interviews identified a number of principles for injury prevention strategies for the future.

### 1. Individuals have the right to be respected and valued.

“We aren’t all bad you know. We do deserve to be treated as equal, not as a low life. Jesus, some of the people I have had in here all bugged up and they’re not just all Koori’s either. Some of my friends are white too, but most don’t like to admit that.”

### 2. The elders need to be recognised and supported to create the future

“They are usually a more refined group. My experience is they are more level headed. There is a greater need for our elders to be more recognised in the communities. I believe our children and our adults should be able to approach elders because they have got the experience behind them. Not often enough are our elders used.”

### 3. The strengths of individuals and families that are doing well should be recognised and celebrated

“I know a young lad about 19 who’s a father himself, who was bought up in a very abusive environment. Where his parents drank, he was abused and neglected by his parents who would just leave him with anybody, he was bought up by everybody else and he doesn’t drink himself he has nothing to show for it but he is a very good dad.”

### 4. The strengths of community need to be restored and valued

“We need to be a much stronger group of people, then we can look after our children and can work on uniting our family again.”

### 5. The strengths of culture need to be rediscovered and practically applied to the present day environment

“We have lost a lot of respect for our elders. Only by returning to our cultural being and instilling that into our kids can we address the problem. We have lost a lot of our community protection and spirit and insight our community needs UNITY.”

## 6. The diversity of cultures should be used as a strength rather than a source of conflict

“My dream would be that they have a place of their own, a space for cultural diversity, a space for the 52 different tribes.

From it, we all grow as human beings in our community because we're part of a just society.”

“If only we could let go of our fears and our prejudice. I feel they are so rich in their culture and we may lose it. I want my grandchildren to experience this culture.”

“There is no simple band-aid approach. It's about empowering Aboriginal Australia, celebrating Aboriginal Australia. Respect, how can anybody who is never shown respect, respect themselves.”

“Making the community safe and welcoming. A safe environment, there's nowhere like that in Mount Druitt.”

## 7. Learn by doing not by talking and theorising

“Stop wasting the money and do what's needed. We know what's needed so do the bloody thing.”

## 8. Build a future for children by modelling respect and safety as adults

“If we're going to regain this respect we need to start with the children so they can teach their children to carry on the self-respect to relate to other people.”

“To have commitment to our children and meet their needs we must as adults provide support factors:  
a safe caring environment,

constant supervision and guidance,

foster the concept of Home for the child,

give clear messages to the child and include the child in decision making that directly effects them and their world - it was shattered for us, let us help them to put the jigsaw together, listen – in order to hear what the child is really saying.”

“Allow the concept of “safe place” where the child feels safe enough to reach out ... in order to reach in and heal.”

“Provide good role models – Heal our own hurt first.

9. Provide good education based on indigenous knowledge and the law of the land

"I would just really like to see health services provided. Factions, nepotism, and power have to go. It's got to do with community development in Aboriginal health."

"There has got to be education for Aboriginal people with no conflict of interest involved."

"In the ideal world we would have glossy posters, educate and run workshops."

"You can't educate the whole community at once. You have to break it down into categories like sport."

10. Provide service structures that provide continuity of care and commitment to long term change and challenge management and planning practices that result in fragmentation and short term experiments.

"It's then about consistency of care. It is no good having a really good AMS if it's not accessible to the people."

"If we're really going to build a safe community we have to work on it 24 hours a day like we do with our own kids. It can't be a 9 to 5 service, it has to be beyond that."

"More flexibility for professional people to work flexible hours. Once you open up the places things start to happen and people start to take care of themselves."

"Most Aboriginal staff are on temporary contracts. Neither they nor their clients know who will be there tomorrow or whether today's priorities will be continued."

## Overview of major findings

As in much of the rest of Australia, routinely available health data are not adequate for detailed profiles of injury among Aboriginal people in Western Sydney. There are a number of factors that influence this. Many injuries are treated in settings that do not systematically report injury data. Data are only readily available from public Emergency Department (ED) systems and hospitals. Health data systems are known to have errors in identifying Aboriginality. Comparison of rates of hospital admissions with non-Aboriginal populations is also difficult due to problems with Aboriginal identification in the census data.

Emergency department data comparisons were not attempted in this report because of the wide catchment area of the large ED departments in the Area and likely differential use of other treatment services for this level of injury. Many injuries appear to remain untreated.

Despite the fact that exact numbers and rates of injury cannot be determined, available data show that injury is a major problem in this Area. In particular, the level and nature of violence and self-harm is of concern. Cultural fragmentation, alienation and poverty appear to be major underlying factors. Accidental injury is also common, and risk-taking, peer group pressure and hazardous environments, increase rates of injury.

Overall the major features to be taken into consideration when planning prevention of injury are:

- the frequency, severity and causes of injury are poorly described and understood
- injury patterns are closely associated with underlying social issues
- role models for children lead to high levels of risk-taking and injury
- peer pressure and status seeking in a poor and alienated community results in severe injuries among adolescents and young adults
- intentional injury is of paramount concern
- violence is widespread
- self-harm is common and erodes the confidence of the community
- the threshold for treatment is high. Injuries are only treated when the injured person and their relatives are convinced that it is safe to seek treatment or the injury is severe
- injury is accepted behaviour in the Aboriginal community. This includes both intentional and unintentional injury, and
- there is a lack of trusted, accepted and effective treatment facilities

Injury prevention efforts must seek to establish for the community leaders and residents that injury reduction is possible. They must be concrete and focussed on action that is sustained long enough to produce results.

Injury prevention programs cannot by themselves right the wrongs or take on the whole agenda on alienation and cultural erosion. They must however recognise the importance of these issues and select priorities and intervention models that seek to redress the deep-seated distrust and anger in the community.

Violence prevention is a major need. The approaches to violence prevention however must be careful not to increase alienation and must not echo the violence that they are designed to reduce. Violence is a universal issue and it needs to be addressed universally. Complementary programs are needed for men, women and children.

The community needs to be assisted to demonstrate that making safe choices in environment and behaviour brings positive and long lasting benefits. They need to identify and celebrate success.

## **Future directions**

The first part of this section echoes the voice of the people. It looks at where we are now and to the future and suggests possible directions to be taken. The ideas have been developed in consultation with the steering committee, elders, key agencies and participants in the project.

The format used is one that has been found to be useful by the World Health Organisation when dealing with complex issues that require community acceptance, understanding and support.

The second part consists of firm recommendations for action. It is focused on policy makers and agencies.

## 1. Violence

### What the community said?

“Elder abuse really worries me because it’s a secret silence like a sneaky little snake where people are manipulated for lots of reasons. A lot of it has to do with respect. Self respect as much as anything. If you don’t respect yourself how can you respect others.”

“Violence oppresses the entire community because it impacts on the entire community and it holds us back from moving forward.”

“For the victim it’s a lack of self-esteem that leads to self-destruction. Mental and emotional. And it has a big impact on the family. They suffer mental and emotional stress. For the community a lot depends on whether they know about it. If they know they will step in and support. A lot of the time they feel inadequate and hopeless.”

“Family violence is accepted and common. The woman working makes the man feel inadequate and forced into a role of DV out of frustration. You can’t just blame one aspect of it. You can’t blame one any more than the other. Nine out of 10 couples who are victims or perpetrators of DV are going to get back together. You have to work in a holistic way with the whole family to stop the cycle of violence.”

### Where are we now?

- Violence is a major problem in the Aboriginal community affecting all ages and families in some way
- Violence is accepted behaviour in the Aboriginal community.
- Violence arises out of frustration and disempowerment
- Violence creates fear and continues disempowerment
- Imprisonment does little to reduce violence but has many other negative effects

#### BUT

- The community does not want to continue to accept violence
- The community wishes to be empowered
- The community wishes to accept responsibility for change

#### AND, the people want

- Action to occur
- To see positive change
- To regain their culture

### Where would we like to go?

- Violence is the exception rather than the rule
- The environment is safe
- Aboriginal people are not labelled and stigmatised as violent
- To live in unity without racism

#### SOMETHING TO TRY

- Culturally appropriate counselling services using a holistic approach to the whole family
- Children to experience positive role models
- People will take responsibility for their behaviour and actively seek solutions
- Helping services for both men and women

#### POSSIBLE PARTNERS

- WSAHS
- Daruk AMS
- Counselling Service
- DOCS
- Education Department
- Marrin Weejali
- Blacktown Council
- Community Solutions
- Police

**How will we begin?**

- Strengthen counselling services with culturally relevant approaches and Indigenous staff
- Build better partnerships between agencies including existing services
- Acknowledge and support staff who are doing well and who have potential to do better.
- Establish a safe place for Aboriginal people
- Initiate men's and women's groups
- Provide positive role models and mentor children
- Assist children to consider other strategies rather than resorting to violence
- Link to existing family violence support groups in the area.
- Personal input from community agencies and leaders.
- Community meetings that focus on action, which include input from relevant people and key stakeholders.
- Use appropriate strategies to link the community together
- Link with pre-schools

**Who else might work with us?**

- Council Of Elders
- Youth Workers/Social Workers
- Correctional Services
- Refuges
- Private Health Providers
- Polyclinic
- DV Workers
- Anger Management Workers
- Aboriginal Children's Service
- Murawina Gwen Delaney Early Childhood Service

**Recommendations (the numbers below refer to detailed recommendations on page 61**

1-5,11

## 2 Alcohol and Other Drugs

### What the community said?

“Alcohol abuse effects the community overall. The effect depends on the position they hold in the community.”

“The attitude of some people is you see one drunk person they must be all like that. It’s not the case.”

“There is a need for drug and alcohol awareness. Without being told the effects, they don’t know. It doesn’t matter. Stop the person from taking it.”

“Older people don’t tend to worry about wounds. We have older men affected with alcohol and they have vitamin deficient wounds and they let them go thinking they’ll fix themselves.”

### Where are we now?

- Alcohol and other drugs are consumed by all ages and both genders
- Alcohol and other drugs are used to ease the pain and suffering experienced by Indigenous people.
- Alcohol and other drugs are an escape from the pain of daily life and loss of culture but often have the opposite effect
- Alcohol and other drug use is influenced by peer pressure
- Alcohol and other drugs are a contributing factor that often leads to addiction, violence, crime and family breakdown.

BUT

- There is clear recognition that the use of alcohol and other drugs are damaging the Aboriginal community and there is strong desire for change

### Where would we like to go?

- Minimise the level of alcohol and other drugs use at all ages
- Affected members develop their awareness and acknowledge and accept assistance
- Affected members acknowledge and accept responsibility for their own lifestyle.

#### SOMETHING NEW TO TRY

- Culturally appropriate men and women’s groups focusing on the well being and self-esteem.
- Vocational training for employment (becoming job ready)

#### POSSIBLE PARTNERS

- Marrin Weejali Aboriginal Alcohol and Other Drugs Service
- Daruk AMS
- Other appropriate alcohol and other drugs services
- WSAHS

### How will we begin?

- Aboriginal organisational members/staff, community and elders to work with the affected community to rebuild their Aboriginal culture and self – esteem
- Consult with the effected community about what they want and need
- Educate the Indigenous community on the harmful effects of alcohol and other drugs, using culturally based strategies
- Culturally appropriate detoxification - healing centres
- Enhance and increase the capacity of existing services to accommodate for larger numbers
- Increase the number of Indigenous alcohol and other drugs services in the area
- Provide appropriate programs to empower the Indigenous community with knowledge, increasing self – esteem and awareness
- Resource the existing Aboriginal alcohol and other drugs services in the area.

### Who else might work with us?

- Aboriginal organisations and community
- Correctional Services
- Police
- Employment Services
- Vocational training providers
- Juvenile Justice
- Office of Probation and Parole
- Department of Education
- Department of Community Services
- Other services relevant to Indigenous needs.

### Recommendations (the numbers below refer to detailed recommendations on page 61

11,4,5,3

### 3 Men

#### What the community said?

“Women say I’m hurting, I better go to the doctor.  
Men are that macho stuff. I’m right and wait till it falls off.”

“What I see with Aboriginal men is that they also need cultural appropriate counselling done by men. The legacy of removal has bought them into a time zone.”

“There are a lot of things in place for women to be able to tap into services if they wish. There should be more places more support services in place is needed for our men.”

“Men don’t show their emotions and speak about what’s bothering them as much as women will.”

#### Where are we now?

- Men experience high levels of all types of injury
- There are few services or groups that cater for the underlying needs that result in injury
- Men have low self esteem
- They experience high levels of peer pressure to take risks
- Men have lost a valued status within their culture
- Men want to be a part of the family unity.

#### BUT

- Many men are aware of the need for change
- The community wants effective male leadership

#### AND

- Men are interested in change
- Injury issues have been shown to be a good starting point for dealing with men’s issues
- Men want to be a part of the family unit (the importance of family needs to be worked on for next meeting)

#### Where would we like to go?

- Men have a valued place in culture.
- Men acknowledge their needs and accept assistance to take responsibility for their actions
- Men recognise that injury can be prevented and are prepared to invest in safety promotion

#### SOMETHING NEW TO TRY

- Men’s groups focusing on men’s well being which includes accidents, injuries, violence and alcohol and other drugs issues
- Men are assisted to become positive parents and role models
- Men receive training to be employed. Including recruitment into the helping professions

#### POSSIBLE PARTNERS

- Daruk AMS
- Holy Family
- WSAHS
- Centrelink
- UWS Men’s health Unit

**How will we begin?**

- Work with the elders to rebuild a model of status for men in Aboriginal culture
- Consult with men about what they want and need
- Initiate men's groups
- Assess the viability of a men's space for private discussion and confidential support by men
- Increase employment of qualified Aboriginal men
- Assist men to understand and be empowered to respond to their legal rights and responsibilities
- Understand more of the treatment of Drugs Alcohol and Gambling
- Address sexual assault issues
- Work with sporting groups on safety and injury prevention
- Conduct a men's camp to assess needs and define directions
- Increased opportunities for employment for qualified men
- Increase opportunities for education qualification for men.

**Who else might work with us?**

- Sporting groups
- Alcohol and other drugs services
- Employment services
- Correctional services
- Justice Department
- Police
- Legal services

**Recommendations (the numbers below refer to detailed recommendations on page 61**

14,15,1-5,11

## 4 Women

### What the community said?

"I reckon most women around here have been either sexually abused or raped. No wonder they are taking drugs and alcohol. I reckon they would have to be bashed up by their partners too."

"I've seen many ladies come in here that have got no confidence whatsoever. That's a big thing looking for a job."

"A lady that had been bashed by her grand daughter. She had a broken arm and lots of bruising and lot of mental stress and not wanting to be there with her granddaughter and not having anywhere to go, so she had to stay there. Nobody did anything to try to get her moved either."

"Another Koori lady had marks all over her body – cuts all up her arms. I think that was DV too. She had 3 children. She was moved on because her non-Aboriginal husband used to go around to the refuge all the time. She came from Taree originally, but he found out where she was. He tried to jump through her bedroom window at the refuge window one night. A worker stopped him and called the police, but he'd run away by the time they had got there."

She used to suffer a lot, I think she had a mental illness, because she was always rousing, she was cranky all the time and swearing all the time and she was always in a deep depression. The kids use to play up on her because she wasn't coping. But when her husband wasn't around she was a nice person."

### Where are we now?

- Women are subjected to violence and sexual abuse from an early age
- Many women take on the role of victim
- Services for women often focus on women's needs without adequate consideration of the whole family needs
- There are more services for Aboriginal women than men and more women employed in these services
- Despite the resources available, progress remains slow.

#### BUT

- Women are committed to change
- Women are more in tune with their health and have a positive role as the main care giver in the family

#### AND

- Women have a lower overall injury rate
- Women actively adopt prevention strategies and are active in the community

### Where would we like to go?

- Women will experience less violence and more safety
- Women empowered to help build a strong Aboriginal society
- Women will retain status as effective caregivers and receive support from their partners and the community.
- Women will have safe places staffed by Aboriginal people for support in times of stress
- Women are assisted to become positive parents and role models through support and education

#### SOMETHING NEW TO TRY

- An Aboriginal Women's Safe House
- Women receive training to be employed. Including recruitment into the helping professions

#### POSSIBLE PARTNERS

- Daruk AMS
- WSAHS
- DOCS
- Community Solutions

**How will we begin?**

- Work with the elders to rebuild a model of status for women in Aboriginal culture
- Consult with women about what they want and need
- Increase employment of qualified Aboriginal women
- Assist women to understand and be empowered to respond to their legal rights and responsibilities
- Develop projects that work holistically with the Aboriginal family
- Inform women of the patterns of injury and the possibilities for prevention and seek their ideas and support for prevention and safety initiatives
- Increase the knowledge of services that are available through personal contact

**Who else might work with us?**

- Western Sydney DV Group
- Holy Family
- Blacktown Council

**Recommendations (the numbers below refer to detailed recommendations on page 61**

14,15,1-5,11

## 5 Children and Youth

### What the community said?

“Children’s accidents are from play, like cuts. Broken bottles and people drinking over there at Bidwell reserve. Most of our kids just play in the streets where they live.”

“A lack of appropriate play spaces. A lot of them just play in the street near their homes.”

“There’s no forgiving of the Black kids their blamed for everything; they’re not welcome into people’s homes, shopping centres or places.”

“There is a lot of abuse among children mental physical. If there is a really bad injury among children the family will take them away to hide it. Back to Bourke or somewhere.”

“I also see a lot of stress with women going into another relationship. The children not his then they’ll have children together then theirs division in the family. You’ve got your children, which are not his and his children.”

### Where are we now?

- Children experience a fragmented culture and are exposed to many poor role models
- Injury is not given it’s true recognition because of the level of conflict and depression in many families
- Injuries are not properly treated and sometimes neglected at time of great stress
- Injury is not just the physical results but also the impact on mind body and soul.
- Children and Youth are governed by negative peer pressure and receive status from meeting dysfunctional norms

#### BUT

- Children and Youth have great potential
- Children and Youth are valued by Aboriginal culture
- Children and Youth are acknowledge by the community as the hope for the future

#### AND

- Children and Youth are eager to learn
- Children and Youth adopt health and safe lifestyles if they are given positive examples

### Where would we like to go?

- Children will have the unconditional right to be safe
- Children will have a positive view for the future and will see safety as a focal part of their vision
- Children’s injuries will be properly and quickly treated
- Children will value their culture and live it in a way that promotes not only their own safety but the safety of others
- SOMETHING NEW TO TRY
- Integrating school programs and adult programs for child wellbeing and safety
- Encourage children to be safety leaders among their peers and in their family
- POSSIBLE PARTNERS
- Department of Education
- Sport and recreation
- WSAHS
- Daruk AMS
- Holy Family
- Aboriginal Youth services
- Westmead Children’s Hospital
- Aboriginal Children’s Service
- Murawina Gwen Delaney Early Childhood Centre

**How will we begin?**

- Work with elders to rebuild their cultural integrity
- Liaise with Aboriginal education assistants in each school
- Visit schools and talk with children about their needs and prevention of injury
- Work with children and youth to rebuild their cultural integrity.
- Assist agencies who deal with adults to recognise the needs of children in the families they work with
- Generate a range of activities for children that provide positive rewards while protecting safety
- Explore employment opportunities with local aboriginal land councils
- Address sexual assault issues

**Who else might work with us?**

- Police Citizens Youth Club
- Western Area Adolescent Team
- Department Of Community Services (Aboriginal children's services)

**Recommendations (the numbers below refer to detailed recommendations on page 61**

1-5,10,12,13,14,15

## 6 Older people

### What the community said?

“Elders, because of a lack of basic reading and writing skills, when they were younger they got away with it. Now this age of technology has made them very reliant on other person, which leaves them open for exploitation.

Key-cards are another problem. Some of them can't remember their pin number so they give it to someone and when they go to get some money out there's nothing left and that causes stress, then they ring us for some kind of emergency relief.”

“Because we have a large population of diabetics, they have trauma to their feet. There are a lot of amputations because of this. Depression, manic depression and mental disorders also contribute to injury.”

“They are usually a more refined group. My experience is that they are more level headed. There is a greater need for our elders to be more recognised in the communities. I believe our children and our adults should be able to approach elders because they have got the experience behind them. Not often enough are our elders used.”

“We have lost a lot of respect for our elders only by returning to our cultural being and instilling that into our kids can we address the problem. We have lost a lot of our community protection and spirit and insight our community UNITY.”

### Where are we now?

- There are very few older Aboriginal people because their lives are shortened by premature disease and death
- The number of injuries to this group is relatively small when compared to non Aboriginal people, but injuries are significant and complicated by diseases
- Older Aboriginal people suffer falls and violence. They are troubled by lack of respect from their children and grandchildren
- Older people are often exploited by their families

#### BUT

- There is growing understanding of the wealth of traditional knowledge held by older people.
- Many older people provide leadership

#### AND

- The community has a strong desire to revitalise Aboriginal culture

### Where would we like to go?

- Older people should be actively involved in discussion of how to reduce accidental injury, violence and self harm in the area
- Older people will have the unconditional right to be safe from harm and exploitation
- Older Aboriginal people should be respected in line with Aboriginal culture

#### SOMETHING NEW TO TRY

- Services that treat the common diseases and illnesses of older Aboriginal people should determine the risk for injury and provide injury prevention strategies

#### POSSIBLE PARTNERS.

- WSAHS
- Daruk AMS
- Holy Family
- Make a Move
- Gilgai Aboriginal Centre Inc.

**How will we begin?**

- An older persons forum to access and value the wisdom of older Aboriginal people in increasing safety in Aboriginal society
- Health services dealing with older people for any reason will routinely assess their risk of injuries and actively follow up on injuries that occur to older people
- There will be increased training among health and other helping professions about the nature and impact of injuries among older Aboriginal people
- Link with existing falls prevention programs

**Who else might work with us?**

- Wangary Home Care Services
- Disability Services
- Ageing and Disability Department

**Recommendations (the numbers below refer to detailed recommendations on page61**

1-5,10,14,15

## 7 Self harm

### What the community said?

“Yes self-harm is a big one, suicide. No they’re not like it all the time until it gets to a time when it takes over their lives.”

“If you sat them down at the beginning they’re not on self-destruct, they’re hopeful, they have to have opportunities and they have to be supported to these opportunities.”

“Given the level of marginalisation it’s amazing there isn’t more (self harm).”

“The mother told me during one of my visits, that she had been hospitalised for self-mutilation. The mother, dad and one son and the girlfriend of the son were all doing it. They mainly cut themselves and burns. They were a pretty scary bunch. I didn’t want to get involved. They had dreadful scares.”

“We’ve moved away from our cultural beliefs. We need to move back to that. I feel that Western Medicine isn’t Appropriate for us. Take for example a GP will see a Koori person and put them on Serepax. And then he is not taking our culture into account.”

### Where are we now?

- Self – harm including self - mutilation, overdosing and suicide is common among Aboriginal people in area.
- The impact of these events reaches far beyond the individuals and families involved, eroding confidence and producing fatalism about the future.
- Mainstream suicide prevention activities are not reaching Aboriginal people.
- There is a lack of counselling and support services.

#### BUT

- Concern about the issue is strong and the community has a desire for action.
- While services are few and stress is high, there are incidents where community support and strength has reduced risk and provided a positive future.

### Where would we like to go?

- The community will be encouraged by examples of positive change and swing behind the programs and people that produce them
- The environmental, cultural and social factors that trigger self-harm will be actively addressed. This includes the role of incarceration in increasing the risk of self harm and the erosion of self esteem through unemployment
- The strengths in the Aboriginal community will be fully utilised in the planning of self-harm reduction
- More Aboriginal workers will be available to support people at risk and treatment responses will be built on Aboriginal understandings of well being rather than on Western medicine

#### SOMETHING NEW TO TRY

- A medium to long term support and counselling service for people at risk
- Healing camps and groups

#### POSSIBLE PARTNERS.

- WSAHS
- Daruk
- Holy Family
- Department Sport and Recreation.

**How will we begin?**

- It is important to demonstrate success. Small initiative with resources provided to a level that can succeed are needed
- We will acknowledge the impact of self – harm on the Aboriginal people in the area support them in their grief and anger.
- Consultation with Aboriginal community to identify needs.
- Spiritual place with wise Aboriginal facilitator from the local Aboriginal community
- Excursions to their own country where they have roots

**Who else might work with us?**

- Suicide Prevention Services
- Aboriginal Grief And Counselling Services.
- Indigenous Churches
- Link Up
- Aboriginal Children’s Service
- Murawina Gwen Delaney Early Childhood Centre
- Butucarbin Aboriginal Corporation

**Recommendations (the numbers below refer to detailed recommendations on page 61**

1-5,14,15,11

## 8 Services

### What the community said?

“Quite a few don’t go anywhere. Hospitals are just bad news amongst Aboriginal people. I’ve taken a number of our people to the hospital. Regardless of what people may say they are looked down upon. They read things into things that aren’t there and they don’t want to go back.”

“The welfare system has taken over our culture and that’s our mentality now. There are no other avenues to go. The family has broken down; there is no culture. There are all these groups out there and it’s not working. It’s our culture we’ve given up. The Community are doing their own thing. Organisations are getting greedier. There is no understanding any more. What is going on in our family unit? There is no community unit any more. I love my people. I want to see my people benefit. I’ve seen good people die and organisations getting greedier and greedier. It’s never going to get any better until we get our culture back. I don’t want us to get hurt any more.”

“The organisations in this area are jealous of each other we have to work together.”

“There’s too much favouritism with the Aboriginal community they pick and choose who they want to fuss over. There’s more people out there that need help and they don’t like asking and when they’re refused they won’t ask again. Confidentially plays a big part in loosing trust within the Aboriginal community.”

### Where are we now?

- Some services are stretched to the limit.
- The planning and management structures of agencies do not permit workers to finish the job and make a lasting difference. Funding is too short term and reorganisation too prevalent
- Some agencies are afraid that others will criticise their performance. They limit communication and act as competitors rather than team members
- The community believes that nepotism and favouritism are prevalent. This undermines the work of the services
- Some agencies have a clear understanding of the contribution they can make to reduce injury, self-harm and violence, but lack a mandate to act

#### BUT

- There are many strong and capable workers in the area
- There is desire for action rather than more drawn out planning
- The community is supportive of reducing fragmentation and separation of services.

### Where would we like to go?

- We would like a cohesive approach to injury prevention and safety by the leading agencies that serve Aboriginal people in the area
- An emphasis on small but decisive actions that bring results
- A climate of trust to be developed between agencies
- A skilful well supported workforce to meet the needs of Aboriginal people.
- Improve training and education

#### SOMETHING NEW TO TRY

- Opportunities to build agencies and community self-esteem through effective injury prevention should be actively pursued
- Identification of the total resources provided for Aboriginal health and social programs in the area and development of new partnerships to use these resources effectively.

#### POSSIBLE PARTNERS.

- All human service agencies in the area
- TAFE
- University’s

### How will we begin?

- Multi-agency consideration of this report.
- An all of agencies gathering and conference to show and tell positive initiatives and identify needs that are not being met.
- A united approach in funding applications relating to injury and safety to State and Federal governments
- Audit the capabilities of people working with Aboriginal people in the area and identify and recognise their skill and commitment. Identify gaps and develop strategies for increasing the involvement of Aboriginal people in the management and delivery of services.
- Inform the community in a unified way of the services available
- Increase the commitment of agencies to work together
- Openly address the rumours of preferential treatment with the community and assess if there is any basis to them and the response required

### Who else might work with us?

- Skills West
- Department of Aboriginal Affairs
- ATSIC
- Whole of Government
- Department of Housing
- Aboriginal Housing Office
- TAFE
- NSW Premiers Department

### Recommendations (the numbers below refer to detailed recommendations on page 61)

6-13,1,4,5

## RECOMMENDATIONS

### Implementing this report

1. Disseminate this report to other agencies to raise awareness of the importance of safety and injury prevention and the many issues and needs identified by the Aboriginal community
2. Create (and seek Elsa Dixon funding) a position to implement the recommendations of this report.
3. Conduct a workshop with the Aboriginal communities within Western Sydney to refine and direct the actions from the recommendations within this report
4. Continue to involve a wide range of organisations and people in identifying strategies for reducing injury and increasing safety by developing and implementing the future directions set out in this report
5. Identify possibilities for implementing the future directions detailed in this report in a way that complements the Premier's Department initiative through Community Solutions

### Health services.

6. Document and better understand Aboriginal community expectations of health services for Aboriginal people and the roles and responsibilities of Aboriginal and non-Aboriginal workers within Western Sydney
7. Ensure that induction courses and in-service training include strategies to increase cultural awareness among staff at all levels in organisations and practices that interact with Aboriginal people
8. Improve identification of Aboriginality in Department of Health data collections in line with NSW Health guidelines.
9. Improve the collection of data relating to injury and its causes in all places where injury is treated including routine collection of text descriptions of causes and develop facilities for processing and effective feedback of information to decision makers and the community.
10. Investigate use of multi- media and other communication and education strategies to raise awareness of injury and safety issues including risk factors and possible solutions
11. Identify opportunities for promoting Aboriginal alcohol management plans and programs and other aspects of Western Sydney Alcohol and Other Drug Action Plan in a manner that builds on the importance of safety and injury prevention.

### **Other services**

12. Develop programs and projects involving more than one sector/agency in partnership with a focus on linking services and building continuity of support.
13. Each agency assess its work and the needs of its clients to determine what contribution can be made to increasing safety and decreasing injury directly or in partnership with other agencies.

### **Broad Community Issues**

14. Provide a series of places for Aboriginal people to gather and recover their cultural heritage. These will include safe places for men and women in both urban and Blue Mountains settings
15. Build injury and safety programs around the culture and traditions of the Aboriginal people, using appropriate means of communication such as story telling and art.

## APPENDIX 1 Interview guide

### QUESTIONS

1. What do you think are the main injuries that happen among Aboriginal people in this area?

Examples:

- Poisoning,
- Broken arm
- Cut foot
- Assault

2. What might the main cause of these injuries be? eg. Car accident, playing footy

3. If any what 'age group' would you say a most at risk (let them say the age groups they think)

0 – 4,      5 – 9,      10 – 14,      15- 19,      20 – 24,      25 – 29,      30 – 34,  
35 – 39,      40-44,      45 – 49,      50- 54,      55 – 65,      65 – 75,      75 and over

Male/Female

4. What do you think are the main causes of these injuries among

- Men
- Women
- Children
- Adolescents/Youth
- Middle aged people
- Elders
  - Environment – potholes
  - Alcohol
  - Carelessness
  - No safety equipment

5. Where do most of these occur

- Footy field,
- Pub,
- Road if road where?

6. Are Males or females more at risk?

7. Are any of these injuries deliberate? Eg. Self-harm/violence?

- Are the people who do this like this all the time or only at certain times? (day, night, weekend)
- Why do you think they are like this at that time? ( pension day, alcohol, other reasons)
- If deliberate what sort of affect do you think these injuries have on the people their families and community?

8. Where do Aboriginal people go to get their injuries treated, e.g., go to the hospital/AMS/GP?

9. What do you think our project could do to stop these injuries amongst Aboriginal people? Eg. When kids are poisoned what can we do?

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- <sup>4</sup> Stewart J, Aboriginal Health Strategic Plan, Western Sydney Area Health Service June 1995
- <sup>5</sup> ABS 1998 Regional Profile, Blacktown LGA cited in Blacktown City Council, Social Plan, Local Government Area Profile Pge1, BBC Consulting Planners November 2000
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