

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

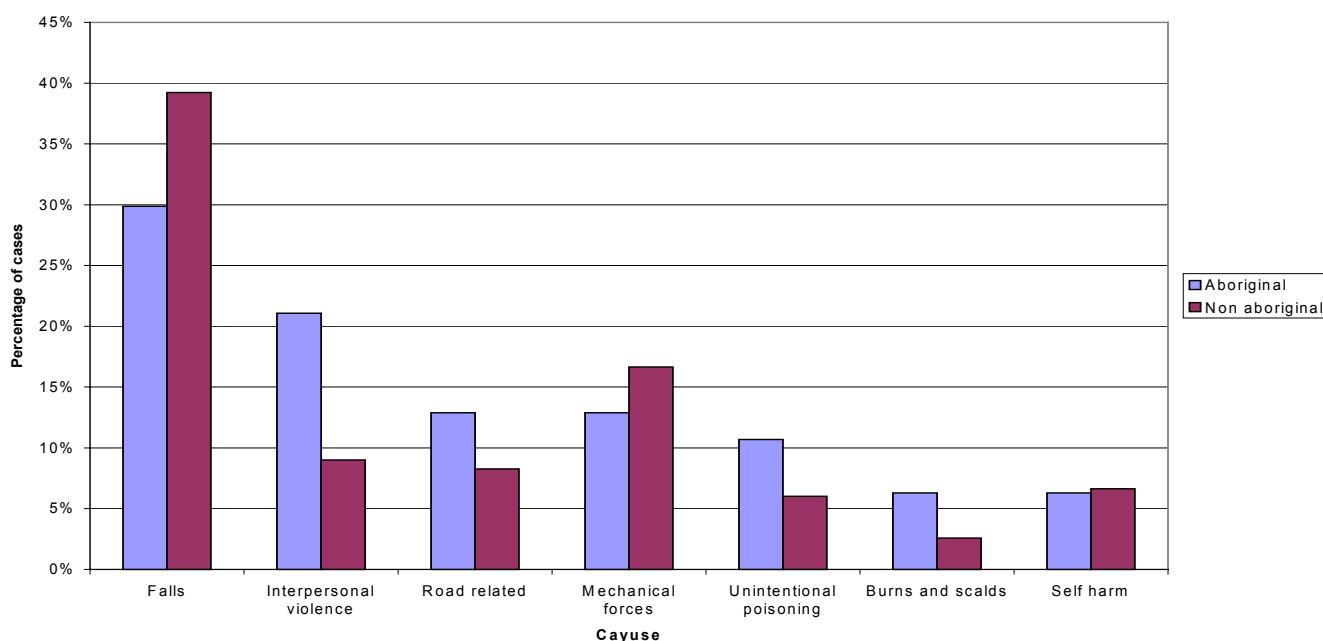


Table 2 compares rates of injury per 100,000 persons for Aboriginal and non-Aboriginal people. This should be treated with caution because there are difficulties in accurately identifying both the injury cases occurring to Aboriginal people and the local population through the Census. In the hospital 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^a, 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 ^a
	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				
TOTAL	318	24350	1824	1838	1.0	2.6

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

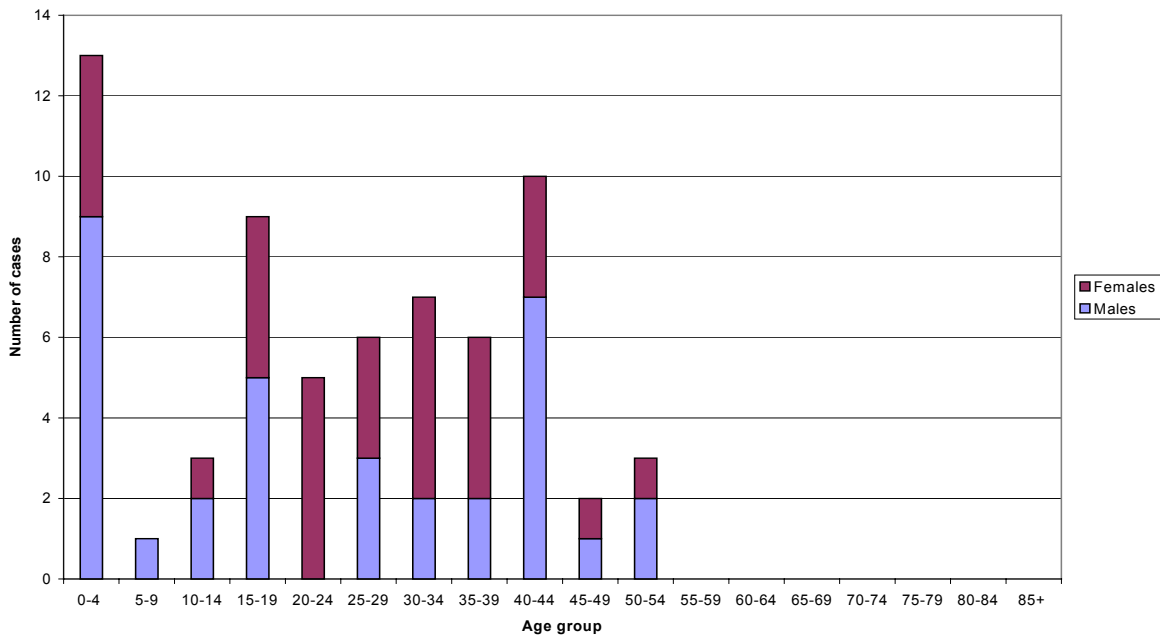
Burn and scald admissions were concentrated in the 0-4 age group. Risks in this age group were four to six times that of non-Aboriginal children with females experiencing slightly higher relative risks than males. Nineteen out of 20 admissions for burns and scalds were among children under five years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

^a 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.

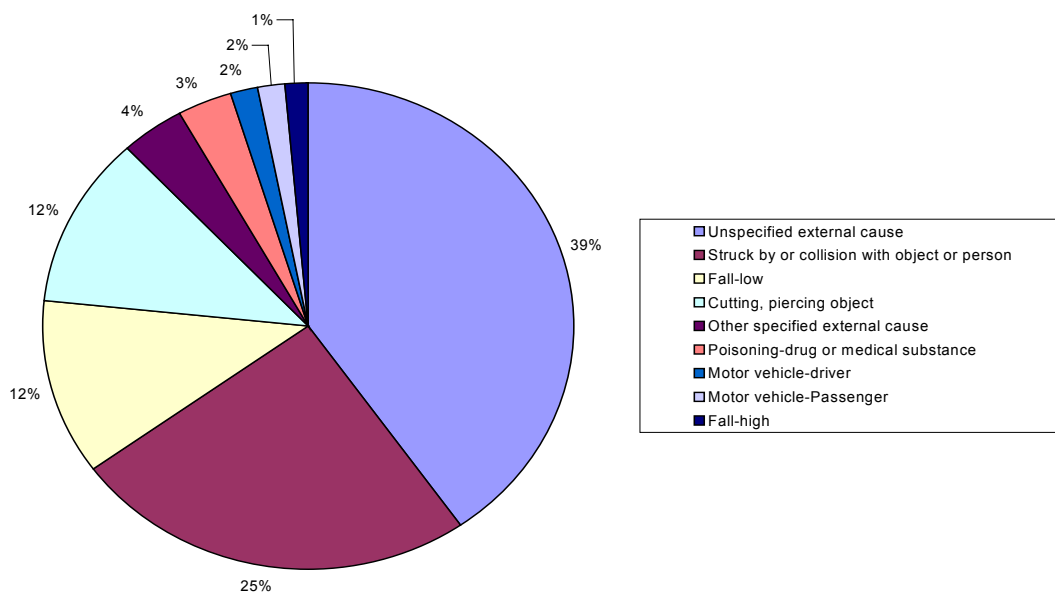
Road related injury

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.

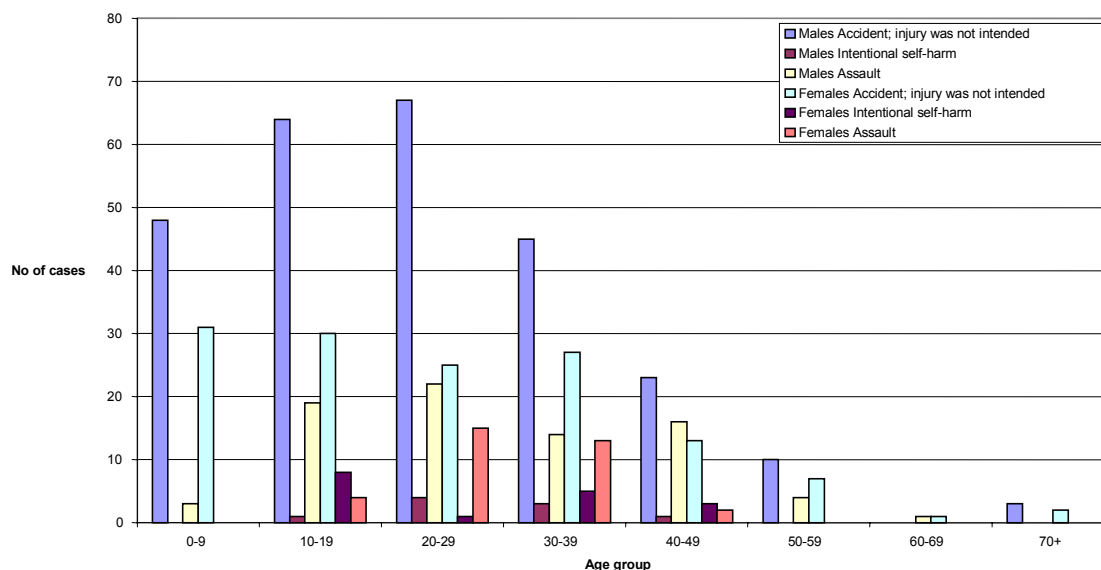
• Figure 3 Major Causes of injury to Aboriginal people Western Sydney Emergency Department presentation 2001-2002



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%
Total	375 (63%)	100%	218 (37%)	100%

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.

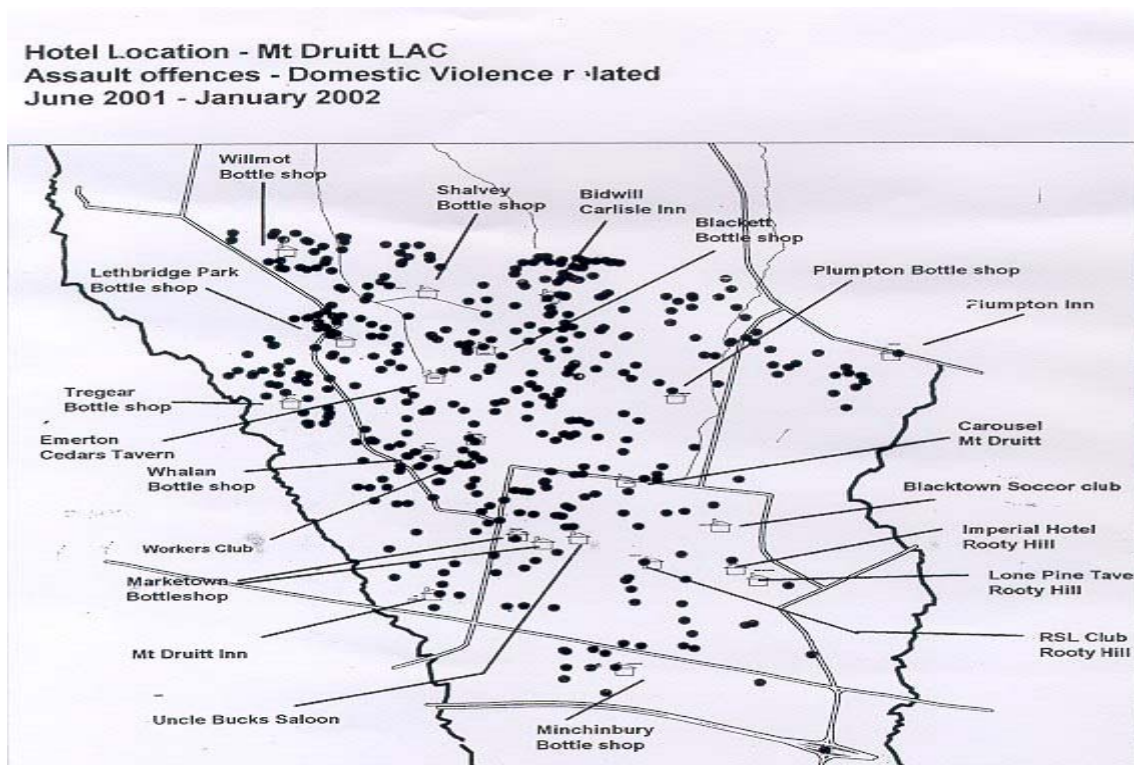
Police data

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)⁷
- 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%)⁸.

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 perpetrators⁹.

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 violence¹⁰.

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 broken⁹.

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 people¹¹.

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.