Appendix A: List of consultations

• Table F - Organisations consulted: location and contact

State/Territory	Name	Position	Organisation
WA	Adele Cox	Indigenous Project Support Officer	Telethon Institute of Child Health
NT	Angela Dowling	Coordinator	Top End Women's Legal Service (TEWLS)
WA	Annalee Steame	Research Assistant	Australian Drug Research Institute, Perth (ADRI)
SA	Caroline Mudra	Researcher	Primary Health Care Research and Information Service, Department of General Practice, Flinders University
NSW	Cat Gander		ATSIC, Family Violence Prevention Legal Services
NSW	Catherine Clarke		Education Centre Against Domestic Violence (ECAV)
Qld	Conde Canuto	Researcher	University of Queensland
NSW	Dale Gietzelt	Researcher	UNSW Centre for Gender Related Violence Studies
Qld	Daphne Nayden	Coordinator	Apunipima Cape York Health Council
Qld	David Eeles	Assistant Commissioner	Queensland Ambulance Service
Qld	David Patterson	Men's Coordinator	Gurriny Yealamucka Health Services, Yarrabah
WA	Debra Clemments	Coordinator	Telethon Institute of Child Health
WA	Dennis Gray	Researcher	Australian Drug Research Institute, Perth (ADRI)
Qld	Ernest Hunter	Researcher	University of Queensland
NT	Fiona Cummins	Lecturer	Batchelor Institute of Indigenous Tertiary Education
NSW	George Shearer	Aboriginal Project Officer	NSW Road and Traffic Authority (RTA)
SA	Georgie Davill	Theatre Administrator	Port Youth Theatre Workshop
SA	Josie Agius	Aboriginal Community Networker	Port Youth Theatre Workshop
Vic	Julian Pocock	Coordinator	Secretariat of National Aboriginal and Islander Child Care (SNAICC)
ACT	Julie Elliott		Department of Family and Community Services
Qld	Les Baird	Health Manager,	Gurriny Yealamucka Health Services, Yarrabah
SA	Liz Fox		Aussinet
WA	Louise Spehr	Regional Road Safety Officer	RoadWise, Kimberley Public Health
NSW	Lynn Luckie	Policy Planning Officer for Aboriginal Health	Mid North Coast Injury Surveillance Project
NSW	Mareese Terare	Coordinator	Education Centre Against Domestic Violence (ECAV)
WA	Marilyn Lyford	Health Promotion Coordinator	Royal Life Saving Society WA Branch
Qld	Melissa Haswell-Elkins	Researcher	University of Queensland
NSW	Nicholas Parkhill	Principal Policy Officer	Drug Programs Bureau, NSW Health
Qld	Paul Elliot	ATSI Coordination Unit	Queensland Ambulance
NSW	Paul Pholeros	National Manager	Health Habitat
WA	Phil Horner	Coordinator	Men's Outreach Service, Broome
Tas	Ralph Mueller	Manager	Aged Care Facility
Qld	Rod McClure	Researcher	University of Queensland
NT	Ros Lague		Department of Family and Community Services
NSW	Rossy Lyons		NSW Family and Community Services (FACS)
NT	Sharron Forrester	Coordinator	Tangentyere Council
NSW	Tim Royal		South Coast Medical Service Aboriginal Corporation, Nowra

Appendix B: Information sheet

Indigenous Injury Prevention Activity project Information Sheet

Background

Indigenous communities suffer nearly three times the rate of fatal injuries than the general community. Instances of interpersonal violence and poisoning are more than ten times more frequent. While there are numerous programs targeted at factors that contribute to injuries (such as substance misuse, domestic violence, road safety and housing), there is a lack of evaluation of the scope of existing programs, their efficacy and their impact of rates of injury.

The project

The Cooperative Research Centre for Aboriginal and Tropical Health in collaboration with Yooroang Garang: School of Indigenous Health Studies, Indigenous Health*InfoNet* and New Directions in Health and Safety is undertaking a review of injury prevention activities in Aboriginal and Torres Strait Islander communities. A reference group, consisting of experts in the fields of injury prevention and Indigenous representatives as well as representatives from the collaborating organisations, has been formed to oversee the project. The project will report to the Department of Health and Ageing to inform the forthcoming National Aboriginal and Torres Strait Islander Injury Prevention Plan.

Aims

To examine and report on the current state of injury prevention activity in Aboriginal and Torres Strait Islander communities.

Objectives

To examine and report on the current state of injury prevention activity in Aboriginal and Torres Strait Islander communities;

To consult with major stakeholders in Indigenous injury to assess their knowledge and experiences of injury prevention activities;

To conduct a comprehensive literature review of Indigenous injury prevention activities in Australia and in other countries, particularly North America and New Zealand;

To review injury prevention policies developed by government and non-government bodies;

To review unpublished research and existing Australian Indigenous injury prevention projects; and

To analyse the data collected with view to recommending strategies for reducing injury rates in Indigenous communities.

Outputs

A report will be produced that presents the information obtained by the project, an analysis and recommendations. It will include discussion of:

- the findings of the consultation process and the literature review;
- existing information on the nature of the injury problem in Indigenous communities;

- the scope of injury, including the amount, circumstances, effects and relevant influencing factors;
- examples of important existing injury prevention activities and programs (including substance misuse, environment, violence, etc.); and
- opportunities to enhance injury prevention activities for Indigenous people.

Outcomes

- Informed policy development for the prevention of injury in Indigenous communities;
- Strategic program development in Indigenous communities for the prevention of injuries; and
- Decreases in the rate and impact of injuries in Indigenous communities.

We wish to identify initiatives, projects and programs that seek to improve the safety and lessen the injury among Indigenous people. Safety and injury issues can include:

- Children's injuries;
- Sports injuries;
- Falls and water injury;
- Self-harm, suicide, violence;
- Domestic violence and sexual assault;
- Substance misuse; and
- Road Injury.

If you have been or are involved in a project that deals with these issues we would like to hear of your successes and failures.

Our work will summarise information from all over Australia and hopefully include information from Indigenous peoples across the world. This will be available free of charge on the Internet so that good ideas can easily be shared.

Please contact:

Dr Kathleen Clapham
Yooroang Garang: School of Indigenous Health Studies
Phone 1800 005343
Fax 02 93519815
E-mail <yg.injury@fhs.usyd.edu.au>

Appendix C: Questions for Injury consultations

Questions: Terms and Definitions

What do you understand by 'health'?

What do you understand by 'health promotion'?

What do you understand by the term 'injury'?

What do you understand by the term 'injury prevention'?

What do you understand by an 'injury prevention program'?

Describing injury in Indigenous contexts

What sorts of injuries occur in Indigenous communities?

Do you think this pattern of injuries occurs in other communities?

What do you think is the best approach for dealing with injuries in Indigenous communities?

Have you seen any programs or interventions that work to improve this situation?

What do you think is required for preventative work to work?

Describe the nature of injuries, which occur in the community/communities in which you live or works or know about?

What kinds of injuries occur?

Which of these do think are most significant for people's health?

Describing injury in a specific or local context

Tell me about an injury incident you have witnessed?

What happened?

Who was involved?

What was your role in that activity? (participant/project worker/health worker/funding agency)

When did it occur?

Where did it occur?

Why did the injury happen?

Could this injury have been prevented? How?

Was this 'typical' in this community?

What was the outcome/impact of that injury?

What factors contribute to these kinds of injuries occurring in your area ? (ask about each factor)

How do these injuries affect the Aboriginal communities in your area?

How concerned are people about this?

How do they effect you?

Preventing injuries

How do you think injuries among Indigenous people (in your area) can be reduced?

Is the prevention of injuries a priority for this community?

What should be done to address these problems?

Who should be involved?

How should the topic be approached within the community?

What sort of approach should be taken to prevent injuries?

What role do Aboriginal health workers currently play in preventing injuries?

Are they prepared enough? eg do they have the skills/resources

Describing an intervention

Describe an injury prevention program or project in which you have been involved?

Tell me about what happened?

What injury problem did it address?

Why do you think it was introduced?

What was the impetus for the injury project?

Who initiated the project?

Who decided on what would happen in the project?

Who was involved in the project?

Who funded the project?

What resources were required to run the project?

Who provided those resources?

What was your part in the program?

Evaluating the effectiveness of an intervention

How well was the nature of the injury problem understood (and described) by the intervention/project?

What information sources did it project draw from?

Was that sufficient information?

How useful is the available information

Outcomes

How successful was the intervention?

What difference has the project made?

What improvements have occurred as a result?

Has it prevented or reduced injury? To what extent?

Would the results have happened anyhow?

Did the intervention reach all who might have benefited?

Would the intervention have helped elsewhere, in different circumstances, or in a different community?

What makes it successful?

Monitoring and evaluation

Was the project monitored and evaluated?

What were the negatives?

Who benefited the least?

How did the community view the intervention/project?

Was it acceptable?

Could it have been done differently?

Who benefited the most from the intervention?

Who benefited least?

How did it affect the community?

In your opinion was it cost-effective?

Could it be replicated in another community?

What was your experience of the intervention/project?

Would you agree to be involved in a similar project again?

How would you get other community members to be involved in injury prevention activities?

Is there anything you would do to prevent injuries that you think hasn't been done already?

Appendix D: Case studies

List of Case Studies

Case Study 1 — Top End Women's Legal Service Aboriginal Women's Outreach Project — Darwin

Case Study 2 — Mid North Coast Injury Surveillance Project

Case Study 3 — The Crossing Aboriginal Pedestrian Road Safety Project, Fitzroy Crossing

Case Study 4 — Woorabinda Community Injury Prevention Project

Case Study 5 — Yarrabah Men's Health Group Project

Case Study 6 — Fixing Houses for Better Health

Case Study 7 — Shoalhaven Injury Surveillance and Prevention Project

Case Study 8 — Tangentyere Remote Area Night Patrol

Case Study 9 — WA Water Safety Projects

Case Study 10 — Safe Dreaming Trails Links Schools Project

Case Study 11 — Family Violence Advocacy Project

Case Study 12 — CommunityLIFE Promotion Project

Case Study 13 — Men and Family Relationship Initiative

Case Study 14 — Community Education Program for Aboriginal and Torres Strait Islander Communities

Case Study 15 — Indigenous "STRONG" Safer Sport Pilot Program

Case Study 16 — Port Youth Theatre Workshop Project

Case Study 17 — Injury Prevention in Indigenous Communities Project

Case Study 18 — Education Centre Against Domestic Violence (ECAV)

Case Study 19 — Family Life Promotion Project

CASE STUDY 1 — Top End Women's Legal Service Aboriginal Women's Outreach Project

Name of project
Top End Women's Legal Service (TEWLS) Aboriginal Women's Outreach Project

Brief description of project/program
The Top End Women's Legal Service (TEWLS) Aboriginal Women's Outreach Project was funded at the end of 1998 and began operating in early 1999. The project involves the employment of Community Legal Workers in Darwin and local Indigenous communities.

Name of organisation conducting the project
Top End Women's Legal Service, Legal Family Violence Preventative Unit

Description of organisation
The Top End Women's Legal Service (TWELS) is one of ATSIC's 13 Family Violence Prevention Legal Service Units (FVPLUs) operating nationally.

Type of intervention
Community-based legal service

Injury problem being addressed
Family violence-related injuries

Dates of project
Began early 1999

Phase
Ongoing

Scope
Regional

Geographic location
Top End Indigenous communities, Northern Territory. In addition to Darwin, the outreach project provides assistance in the Kunbarllanjanja community (Oenpelli), Jabiru, Wadeye community (Port Keats) and the communities of Angurugu and Umbakumba at Groote Eylandt.

Target population
Women and children — victims of family violence

Funding body
Originally the Commonwealth Attorney-General's Department — more recently ATSIC

Partnerships
The project has good linkages with a wide range of relevant services in the region.

Other sources of information available about the project
<tewls@fcl.fl.asn.au>

Future directions
The project has been recently evaluated (see Evaluation of the Effectiveness and Efficiency of ATSIC Family Violence Prevention Legal Service Unit (FVPLU) in Darwin Final Report — 7 May 2001). It is ongoing.

Background

The ATSIC Family Violence Prevention Legal Service Unit (FVPLU) in Darwin is one of 13 Family Violence Prevention Legal Services (FVPLS) funded under the Family Violence Legal Prevention Program (FVLPP). These services are intended to provide culturally-appropriate advice and information in relation to family violence issues. This includes immediate assistance to the victims of violence in the form or legal assistance, counselling and practical support, as well as through preventive measures, such as community education. Each unit operates with a service model designed to meet the different needs of clients in the communities they service.

Interview

A phone interview was carried out with Angela Dowling, Coordinator of the Top End Women's Legal Service.

Family violence was described as:

> What's going on at the time. In "troppo season" — the hot season — assault and riots increase … Alcohol and drugs, poor living conditions, overcrowding, a whole lot of stressful situations — "You could probably write ten pages about it".

The service provides for 4 communities support that includes: monthly visits by a lawyer and a community development worker working with two locally employed community women as Community Legal Officers to support women in court in family violence-related cases:

> Run regular legal information sessions with the permission of women clients (and often they want this);
>
> Speak to men before a case (but can't actually give advice) and after the hearing women want us to explain to the men what the violence order means. (Violence order means the family can still live together);
>
> Give legal info — options;
>
> Help women to go to the police;
>
> Help women to go to a safe house;
>
> Organise family/spouse meetings;
>
> Teach/support community legal officers how to work with clients — inform them, take their story down; and
>
> Prepare stuff for court.

The model used is based around what the community wants, using local women in key positions. It aims to sort things out within the community in preference to using the court structures if possible. The project currently runs in 4 communities:

> We were running a similar program prior to the funding. So when it was available we had consultation sessions with each community to see what they wanted — how they would want the service to run — so the service runs differently in each community according to what they wanted. They wanted to employ local women.
>
> We engage with the community in a holistic way — not just come in a do the work but keep connected and be involved in wider community situations — even if staff change we keep up the regular visits. We try to stay really flexible. You can't expect to work the same way as in the city.
>
> We have a good relationship with community councils — we ask their advice and guidance and inform them. … Each community decided how they wanted things to run.

Originally the legal service was set up with funding from the Commonwealth Attorney-General's Department. After a year, the service saw the need to service remote communities and put in a submission to ATSIC, which initially provided funding for two communities. The funding continued and was provided to service as a Legal Family Violence Preventative unit for 4 communities.

Sources of information for the project were: local knowledge and experience of community workers and community members, work experience, personal and family experience of living in communities and legal knowledge of the coordinator — who previously worked at an Aboriginal Legal Service (ALS) — and legal knowledge/information.

How successful was the intervention?

> The project is "not perfect" — there is still some family violence on the communities but there are some good stories of men who have reduced or stopped violence. And there are still some bad stories.

The service won an Australian Family Violence Prevention Award from the Australian Heads of Government department in 2001.

The women community workers (there are 2 on each community) are getting support for the work they do from their families and their husbands. These men are often prominent community members who have a lot of influence on other men in the community and can be role models.

The community can see the change — community attitudes towards family violence are changing. People say, "Oh, he can't do that — the CLW's (community legal worker) there". They act as a deterrent.

Evaluation

ATSIC employed a private contractor to do an evaluation. It was "quite favourable" A lot of recommendations came out of it. The model was very good. The support is primarily for women and has benefited women and children:

> We support the women and give them their options. The ALS's won't deal with family violence issues, which is a real problem for us. The perpetrators are often left out. Often they have no idea of what is going on. They are "shamed" at court — its' not appropriate. It takes away his power. And if he breaches often he doesn't know the consequences. Sometimes we step outside the boundaries — but we're can't really give advice.

Relationship with the community

The project appears to have a good relationship with the community:

> Some people don't like what we do, e.g. some perpetrators don't like us. But there is definitely an awareness that we're there.

The project works according to what the community wants:

> We are there for the community not the other way. Its their community, they've allowed us in. We have to fit in with the community, they don't have to work around us.

Cost-effectiveness

The project is seen as very cost effective:

> ATSIC are getting more than good value. They only provide funding for 10.2 months so we always need to find some top up to continue running for the whole year. It's important to keep up the monthly visits to each community as the community workers need our regular support, but if there is not the extra money we can't run or go out to a community if something dramatic comes up. We are on a very small budget and people are doing a really good job. The 8 women working from the 4 communities get a low wage directly from us. (They are allowed to keep their CDEP or family allowance also if they are receiving these benefits.) They are very dedicated workers.

The recent evaluation of the Top End Women's Legal Service Aboriginal Women's Outreach Project described the project in this way:

> The project is highly regarded and it is seen to be a vital service … The Project is undoubtedly an example of innovative best practice …T he model has strong elements of community empowerment, community engagement and ownership. The model is culturally appropriate and it is addressing the logistics of quality service delivery for remote communities. (Evaluation of the Effectiveness and Efficiency of ATSIC Family Violence Prevention Legal Service Unit in Darwin Final Report — 7 May 2001)

CASE STUDY 2 — Mid North Coast Injury Surveillance Project

Name of project
Mid North Coast Injury Surveillance Project "Pride, Respect and Responsibility"

Brief description of project/program
The Mid North Coast Injury Surveillance Project (phase 1) described the incidence, nature and causes of injuries experienced by Aboriginal people treated at three selected hospital emergency departments on the Mid North Coast of NSW, over a 12-month period from 1 July 1999 to 30 June 2000. With the support of the Mid North coast Aboriginal Health Partnership, the project used qualitative methods to describe the injury experience of Aboriginal people and community as a whole. Phase 2 involved the development of a better practice model. The projects were funded through NSW Health, Injury Policy Prevention Unit.

Name of organisation conducting the project
Mid North Coast Aboriginal Health Partnership

Description of organisation
The Mid North Coast Aboriginal Health Partnership is a collaboration between Biripi Aboriginal Corporation Medical Centre, Durri Aboriginal Corporation Medical Service and the Mid North Coast Area Health Service. The partnership agreement was first signed in October 1998 and renewed for 5 years in October 1999.

Type of intervention
Injury surveillance

Injury problem being addressed
Injury prevention

Dates of project
Data was collected from 1 July 1999 to 30 June 2000.

Phase
Phase 1 and phase 2 have been completed.

Scope
Regional project

Geographic location
Mid North Coast, NSW

Target population
Mid North Coast Aboriginal communities

Funding body
Injury Prevention Policy Unit, NSW Health

Partnerships
Biripi Aboriginal Corporation Medical Centre

Durri Aboriginal Corporation Medical Service

Mid North Coast Area Health Service

The Injury Prevention Policy Unit, NSW Health, and the Mid North Coast Area Health Service administered the project.

Other sources of information available about the project

Mid North Coast Aboriginal Health Partnership 2001 Mid North Coast Aboriginal Injury Surveillance Project Report "Pride. respect and responsibility" Pt Macquarie Mid North Coast Area Health Service.

Future directions

Phase 1, data collection and analysis, and Phase 2, development of a better practice model, have been completed. Funding is currently being sought to implement the model.

Background

The project attempted to describe injury patterns, subsequent 'risk factors' and identify responses to enable positive change among Aboriginal people resident within the Mid North Coast region of NSW. It replicated relevant elements of the methodology used in the Cape York Study (Gladman et al 1997). The project used emergency department data, hospital separation data, and qualitative methods, including event narratives, semi-structured interviews and focus groups. In additional, the study attempted to determine the accuracy of identification of Aboriginal status recorded in routine data collections. The project was designed to be a catalyst for action.

The study found an overwhelming correlation between alcohol and:

- interpersonal violence;
- falls;
- lacerations; and
- transport-related trauma.

Informal sporting activities were also particularly evident as a main cause of injury.

Interview

A site visit was undertaken to Port Macquarie, NSW, and a face-to-face interview was undertaken with Ms Lynn Luckie, Project Officer, employed for phases 1 and 2 of the project. The following comments are from the interview.

What do you understand by the term 'injury'?

> The term injury often carries a meaning that implies physical harm. Injury is more than just hurting yourself physically. Many injuries, especially in the Aboriginal community, have long-term effects on the community. An example is when a death occurs in the community, it affects the entire community.
>
> The community must first identify that injury is a priority for that community. Once identified, the community should be involved in identifying and assessing the risks and managing the processes to rectify these.
>
> The injuries that occur in Aboriginal communities in the Mid North Coast have been identified as leisure activities (informal sporting activities were also considered as leisure activities), poor environmental management and the study also showed an overwhelming correlation between alcohol and injury.
>
> The best approach is the one recommended in the MNC project. This approach involves the appointment of Aboriginal Safety Liaison Officers (a total of 4 officers for the area). These officers would be employed in Aboriginal-identified positions and would be responsible for risk

assessments in the community. Community members would be encouraged to pass on their concerns through these officers. These officers would then contact the relevant agencies to rectify.

There needs to be an interagency approach to injury. Agencies such as RTA, police, local Aboriginal land councils, Aboriginal medical services, NSW ambulance, local government all need to be involved. It is proposed that the model form the basis for the implementation of a sustainable structure for inter-governmental and community collaboration in the rectification of community hazards which are associated with Aboriginal injury.

The sorts of injuries that occur include falls, pushbike accidents, car accidents, alcohol-related injuries, swimming, violence, poisoning, pedestrian. All of these are significant, however I believe that alcohol-related injuries may cause the most significant ongoing implications for people's health.

Is the prevention of injuries a priority for this community?

Yes. As a result of this project, communities were able to acknowledge the significant role in which they could play to reduce the risks associated with injury.

Aboriginal communities have only too often been involved in arduous processes, studies or trials trying to ascertain appropriate strategies to address competing health or environmental priorities, which have often resulted in poor outcomes. I believe that the best practice model associated with this project offers positive approaches.

In order to increase capacity for injury surveillance NMDS-IS level 1 needs to include cause of injury and not only basic data related to injury events.

As stated before, injury should be approached from an interagency perspective. Agencies mentioned before should all be involved. There will be no evidence of positive change until all key agencies identifying Aboriginal injury prevention as a priority area collaborate and financially commit themselves to the development of a necessary infrastructure and partnership through which community-based injury prevention initiatives can be implemented.

Aboriginal Health Education Officers and Aboriginal trainee EHOs are currently the officers involved with these issues. Increasing education and promoting awareness is definitely a priority.

The best practice model recommends the employment of specific officers to deal with injury risk assessment and management. The budget for the model includes education, toolkits, cameras, mobile phones, protective clothing, travel, motor vehicle expenses, etc.

What was your part in the program?

There was a project officer employed for phase 1 and 2. My role has been and will be the implementation of the best practice model and the recommendations of the report. I have also been involved in the development of the NSW Injury Strategy.

Quantitative information consistent with the National Minimum Data Set for Injury Surveillance (NMDS-IS Level 1) was collected for a 12-month period for people treated at hospital emergency departments in the area. Qualitative information was gathered through focus groups, semi-structured interviews and event narratives.

What difference has the project made?

> An immediate outcome resulting from the project has been that communities have acknowledged the significant role in which they could play to reduce the risks associated with injury. This included the identification of acceptable structures for the future coordination and cooperation of various health sectors and other relevant agencies programs to enable positive change in relation to Aboriginal injury. …
>
> If we obtain funding for the best practice model pilot project, the increase of Aboriginal employment and the provision of opportunities to gain qualifications in specialised health and environmental fields will be a real positive.

Was the project monitored and evaluated?

> The project has yet to be evaluated. The best practice model has included the evaluation in the budget.

In your opinion was the project cost effective?

> Yes

Could it be replicated in other communities?

> Yes, with appropriate consultation.

How did the community view the intervention?

> The Mid North Coast is in the unique position of having a very successful Aboriginal Health Partnership. These close ties with the communities through the partnership enabled positive outcomes. …
>
> It is essential that Aboriginal origin information and that information relating to injury is consistently collected.

CASE STUDY 3 — The Crossing Aboriginal Pedestrian Road Safety Project, Fitzroy Crossing

Name of project
The Crossing Aboriginal Pedestrian Road Safety Project, Fitzroy Crossing

Brief description of project/program
The Crossing Aboriginal Pedestrian Road Safety Project was a pilot project that aimed to reduce the number of pedestrian fatalities and injuries among Aboriginal people living in the Fitzroy Valley region of Western Australia.

Name of organisation conducting the project
WA Local Government Association — RoadWise

Derby/Fitzroy Crossing RoadWise Committee

Shire of Derby/West Kimberley

Nindilingarri Cultural Health Service

Organisations and community groups from the region

Description of organisation
Collaboration between local government/local community groups

Type of intervention
Road Safety Education Awareness Campaign — school education

Injury problem being addressed
Road Injury, pedestrian injury

Dates of project
The project began in July 2002 and will be completed by the end of March 2003.

Phase
Ongoing

Scope
Local project

Geographic location
Fitzroy Crossing, WA

Target population
Pedestrians in the Indigenous community

Funding body
Healthway provided the bulk of the funding for the project, providing money for resources and promotion. The WA Local Government Association — RoadWise — paid for the wages, the car and office equipment expenses. Main Roads WA donated road signs. The Black Spot funding (WA Main Roads) provided money for street lights (this has to be applied for through the local Derby Shire Council). Derby Shire Council provided staff to put up road signs.

Partnerships
The project adopted a holistic approach to address many of the risk factors, and involved organisations and community groups from the region working together to implement the strategies.

Other sources of information available about the project
Cercarelli, L. (1999). *Road crash hospitalisations and deaths in Western Australia involving Aboriginal and non-Aboriginal people, 1988 to 1996*. Perth: Department of Public Health, University of Western Australia.

Data Analysis Australia. (2000). Analysis of Road Crash Statistics Western Australia 1990 –1999.

Department of Transport. (1998). *The Way Ahead. Road Safety Directions for Regional Western Australia — Kimberley Region*.

Kimberley District Police Office. (2001). Reported Road Crashes Database.

Rosman, D.L. & Knuiman, M.W. (1994). A Comparison of Hospital and Police Road Injury Data. *Accident Analysis and Prevention*, 26(2), 215– 222.

Future directions
Post-intervention surveys are being carried out to assess the target groups behavioural and attitudinal changes as well as their views on the environmental improvements , for example the installation of lighting.

Lobbying of local government to install footpaths and lighting on other streets in town.

Ongoing monitoring of crash statistics involving pedestrians.

Background
The specific health issue this project addressed was injuries in Aboriginal people — in particular, deaths and injuries as a result of road crashes. There is a large amount of evidence to show that Aboriginal people in Western Australia and the Kimberley are over-represented in road crashes, particularly "Hit Pedestrian" type crashes.

In Western Australia between 1988 and 1997, there has been a general increase in the number of serious crashes involving Aboriginal people. It was found that the majority of Aboriginal crash fatalities were male, and over 60% were aged 21 to 39 years. It was also found that passengers were the most common Aboriginal fatality, followed by pedestrians (Data Analysis Australia, 2000).

Cercarelli (1999) found in her research that, between 1988 and 1996, the majority of road deaths involving Aboriginal people involved "Non-Collisions" (33.1%) and "Hit Pedestrian" (24.6%) compared with only 14.5% and 12.8% respectively for non-Aboriginal people. She also found that Aboriginal people were three times more likely to be hospitalised because of a "Hit Pedestrian" type of crash than non-Aboriginal people.

In the Kimberley in 1998, the rate of Aboriginal hospitalisation from road crashes (785 per 100,000) was three times the rate for non-Aboriginal people (239 per 100,000) (Department of Transport, 1998). Research undertaken by Data Analysis Australia (2000) for the Department of Transport WA found that, between 1990 and 1999 in the Kimberley, alcohol was present in 51% of all fatal crashes. The most common fatal crash nature types were "Overturns" (39%) and "Hit Pedestrian" (28%) crashes.

From Jan to Nov 2001, in the Kimberley, there was a total of 18 serious traffic crashes, which resulted in 7 deaths and 17 serious injuries. Pedestrians accounted for 2 deaths and 3 serious injuries, and alcohol was a factor in 10 (55.5%) of all crashes. Five crashes occurred on secondary roads and 1 in a remote community (Kimberley District Police Office, 2001).

Data obtained from the Kimberley District Police Office (2001) for the Fitzroy Valley region found that, on Fitzroy Crossing's Sandford Road (which is the road leading from one of the town's major drinking venues to the main town and communities) for the four-year period between 1998 and 2001, there was a total of 3 Aboriginal pedestrian fatalities. Two of the three fatalities occurred after dark, and the third occurred just after sunset.

Many road crash injuries are not reported to police, and the severity of injuries is often misreported in police data as well. This is particularly evident in rural and remote areas where many Aboriginal people live. The closest police station can be up to 300 km away and therefore the crashes often go unreported; many people are also unaware of the reporting requirements for road crashes. Previous research by Rosman and Knuiman (1994) found that under-reporting was greater for crashes involving Aboriginal people.

Interview

A phone interview was conducted with Louise Spehr, RoadWise Regional Road Safety Officer.

RoadWise addressed the issue of high rates of pedestrian fatalities and injuries in the town of Fitzroy Crossing, WA:

> Walking is one of the main forms of transportation for Aboriginal people in the town of Fitzroy Crossing and, as a result, Aboriginal pedestrian fatalities and injuries are high with almost one pedestrian fatality or serious injury per year over the last five years. …
>
> There are essentially three main roads that take most pedestrian traffic in Fitzroy Crossing. These roads lead to the two local hotels, and it is not uncommon to see up to 250 people walking along these roads over a 24-hour period. The Shire of Derby/West Kimberley received a Black Spot funding grant to install solar powered lighting and speed humps along one of these roads, and this project will complement the shire's initiative with some community education in the hope of achieving some behaviour change amongst pedestrians in the region.

Identification of risk factors

The project was initiated after a needs assessment found a number of contributing risk factors, included the following.

Apart from the high levels of traffic and road conditions:

> … high levels of tourist traffic during tourist season (May–Oct), including buses; no linear or physical barriers between vehicular traffic and pedestrians on many roads; speeding vehicles and excessive speed limits on some roads; a lack of street lighting and footpaths; and roads leading to drinking venues feature floodways, one-lane bridges, crests and curves which obscure the vision of motorists.

There were a number of other factors identified including —

1. Visibility:

> Aboriginal pedestrians are difficult to see at night because of skin colour and a tendency to wear dark clothing.

2. Knowledge of road safety:

> … poor attitudes to and knowledge of pedestrian road safety.

3. Alcohol:

> … walking whilst intoxicated is common amongst many pedestrians.

and

4. No alternative means of transport, related to economic factors:

> there is a lack of taxi's at peak times and taxi fares are expensive …

The project adopted a holistic approach to address many of the risk factors, and involved organisations and community groups from the region working together to implement the strategies.

Strategies

A number of strategies were utilised to emphasise to Aboriginal people the risks involved in walking while intoxicated, and to encourage a change of present attitudes and behaviours in relation to walking along roads at night in the town. The project also addressed the issue of pedestrian visibility for local motorists and tourists by educating them to be aware of pedestrians on the road and to also encourage pedestrians to be more visible to motorists at night.

Louise Spehr, RoadWise Regional Road Safety Officer in the Kimberley, initiated the project as part of the WA Local Government Association. Louise initiated the project in conjunction with the local Derby/Fitzroy Crossing RoadWise Committee, and then prepared the funding submission. Further consultation then was conducted with local Fitzroy Crossing and other organisations/agencies, including: the school; Nindilingarri, the local Indigenous cultural health centre; the Kimberley Aboriginal Law and Culture Centre; the local hotel, the Crossing Inn; the Safer WA committee in Fitzroy Crossing; Kimberley Public Health Unit; and local community members.

Healthway provided the bulk of the funding for the project, providing money for resources and promotion. The WA Local Government Association, RoadWise, paid for the wages, the car and office equipment expenses. Main Roads WA donated road signs. The Black Spot funding (WA Main Roads) provided money for street lights (that has to be applied for through the local Derby Shire Council. Derby Shire Council provided staff to put up road signs.

The Project Officer looked at the road statistics, identified where injuries occur and developed strategies to address the problems. She consulted with the local RoadWise committee, prepared submissions, decided on objectives and strategies, and did a pre-project survey to assess local understanding of the issues. She also consulted with a range of local people and organisations to ensure strategies would be accepted. A local Indigenous person worked as an interpreter to explain the project. The Project Officer ran school-based children's road awareness talks about staying safe on the roads and walking at night — "walksafe" and a poster competition. The 5 winning posters were enlarged to make street signs, which were to be placed on the road where the highest rate of accidents occurred. The Project Officer lobbied the local shire to improve street lighting, road signage, footpaths and road edges. The Project Officer also funded and supported a local organisation to produce radio advertisements using elders to speak on road safety in language and Kriol. 1500 reflective wrist bands were distributed to people in places where they most commonly walk and where they brought their grog — working with the local Aboriginal cultural health mob to explain things in language:

> During the pre-project base line survey with local people, they were aware of the dangers: 100% of people surveyed said they didn't feel safe on the roads — 90% attributed it to lack of lighting, 10% to lack of footpaths. Alcohol wasn't mentioned as such an issue. But alcohol is an issue. Once people are intoxicated, they tend to walk on the road and are not aware of cars and don't think to get off the road.

Results

Some of the results of the project include: new warning signs on the road, more lighting, and more awareness of issues. No injury has occurred in the 6 months from the beginning of the project. Previous to that, in the last 5 years, there had been at least one injury or fatality in each 6-month period:

> They now have lights along the most dangerous stretch of road. No injuries in the last 6 months.

Success of the project

The success of the project depended on having a project officer to drive it:

> If I hadn't been driving it, it might have ground to a bit of a halt. People had enthusiasm but I had to push a bit. Still got outcomes but they took a bit longer than anticipated. Might be partly due to cultural difference in approach..
>
> The project reached a good section of the community.

Evaluation

> Monitoring was achieved through spot interviews undertaken during the project, but no post-project evaluation

As far as the project officer could tell, the community viewed the intervention favourably:

> The local organisations have been really good and were happy to work with me. …
>
> All up the project cost $10,000. Which was definitely good value.

Transferability

> The project could be replicated in another community. It's going to be done in Halls Creek. WA Health and the WA Police Road Safety Section heard about the project and are providing funds towards it.

CASE STUDY 4 — Woorabinda Community Injury Prevention Project

Name of project
Woorabinda Community Injury Prevention Project

Brief description of project/program
The Woorabinda Community Injury Prevention Project is a collaborative project between the Indigenous Health Program, University of Queensland, and Woorabinda Community Council. It attempts to address injuries through the identification of 'community owned strategies for injury reduction'. The project is focused on Woorabinda, a Queensland Aboriginal rural community with a history of forced relocation and a population of around 1000 people. It involves the collection and analysis of extensive epidemiological data and the identification of patterns of injury. The program is now working with community people to explore initiatives identified through community consultation.

Name of Organisations Conducting the project
Indigenous Health Program, University of Queensland

Woorabinda Community Council

Queensland Health

Description of organisation
University/local community council/State health department

Type of intervention
Injury surveillance

Community development

Injury problem being addressed
All injuries at a community level

Dates of project
The project began in 1997 and is ongoing.

Phase
Ongoing

Scope
Local project

Geographic location
Woorabinda community is located 160 km inland from Rockhampton.

Target population
Local Indigenous community

Funding body
Queensland Health

Partnerships
Indigenous Health Program, University of Queensland

Woorabinda Community Council

Queensland Health

During the project, partnerships were also established with community services officers (youth workers, sports and recreation officers, the Management of Public Intoxication program, local justice initiatives). At the regional level, the project collaborated with Queensland Health (Health Promotion, Alcohol and Other Drugs), the Liquor Licensing Commission, the Department of Family Services and the Queensland Police.

Other sources of information available about the project

Professor Cindy Shannon, Indigenous Health Program, University of Queensland, Edith Cavell Building, Royal Brisbane Hospital, Brisbane, Qld 4029, phone 07 33464619, e-mail <c.shannon@sph.uq.edu.au>.

Indigenous Health Program, University of Queensland website <www.acithn.uq.edu.au>.

Shannon C, Young E, Haswell-Elkins M, Hutchins C, Craig D, Kenny G, McClure RJ. 'Injury prevention in Indigenous communities: An example of policy to practice' *Health Promotion Journal of Australia* 2001; 12:61–66.

Shannon C, Young E, Canuto C, Craig D, Schluter P, Kenny G, McClure RJ. Injury prevention in Indigenous communities: Results of a two-year community development program *Health Promotion Journal of Australia* 2001; 12:43–47.

McClure RJ, Shannon C, Young E, Craig D. 'Injury prevention in Indigenous communities: Rationale for concentrating on community management' *Health Promotion Journal of Australia* 2001; 12:148–151.

Craig, D., Kenny, G., Young, E., Haswell-Elkins, M., McClure, R. and Shannon, C. 'Injury Prevention in Indigenous Communities: Aboriginal Community Members talk about Injury', *Injury Prevention in Indigenous Communities Working Paper No. 3.* Woorabinda Aboriginal Council, Indigenous Health Program, Australian Centre for International and Tropical Health and Nutrition, the University of Queensland.

Future directions

Interpretation of information collected in stage one of the project will be conducted within the community and fed into the formulation of priorities and strategies to prevent injury. Outcomes of these interventions will be apparent in the data obtained from the existence of an on-going injury information system.

Background

The Woorabinda Community Injury Prevention Project was initiated through a collaboration between key members of an Aboriginal community and the Indigenous Health Program, University of Queensland.

The project involved the collection of injury data by a range of formal and informal means, including key informant interviews, participant observation and 'yarning' to gather information about the community's concerns about injury and their knowledge and attitudes towards injury issues. Data collected through focus groups, which used photos of well-known injury trouble spots around the community, provided insights into community concerns and their suggestions for how injuries could be prevented. A household census was undertaken to obtain population demographics. Medical record data was collected through the local community medical clinic. This information allowed for recording of detailed information about injuries treated at the clinic. Information was recorded using an injury surveillance form developed by the Queensland Injury Surveillance and Prevention Project. An environmental safety audit of public spaces within the township was conducted and potential hazards identified.

Participants in the focus groups were asked to describe the sorts of injuries they associated with photographed sites and to suggest strategies for dealing with them. They were also asked about who inside or outside the community had responsibility for them.

Some of the injury issues addressed by the project were alcohol- and violence-related injury, domestic violence, safety of mothers and children, youth and the environment. Practical suggestions were made for preventing injuries in these areas. Fights, falls and head injuries in the pub could be prevented by making the pub environment safer through the use of rubber flooring instead of concrete. Better policing at the pub and in domestic violence situations was seen as potentially reducing injuries. Other suggested solutions for domestic violence injuries were the establishment of a men's group and counselling services. Child injuries, such as cut feet from broken glass, were seen to be preventable if parents took more responsibility. Addressing youth boredom was recognised as a top priority. Lack of organised sports and recreation activities were seen to lead to violence, intoxication, and destruction of buildings and self-harm. Structural solutions to local roads — for example raising existing speed bumps — were suggested to address transport injuries. Broken glass and dog bites were common causes of injury.

Many of the interventions proposed by the community were within the parameters of well-known harm reduction and primary prevention approaches. The project indicated a high level of community support for harm reduction strategies.

Community consultation

Consultation with Aboriginal health workers, the community council and the Elder's Committee was sought initially to develop the project's framework and basic guiding principles. The project shows a strong commitment to the principle of community involvement in all aspects of the program.

Outcome

This project developed a community-owned model for Indigenous injury prevention, which has been discussed in a number of recent publications (see 'Other sources of information available about the project' earlier in this case study)

Shannon C, Young E, Haswell-Elkins M, Hutchins C, Craig D, Kenny G, McClure RJ. (2001) identify the following elements as needing to be addressed if injury prevention programs are to make an impact in Indigenous communities:

- understanding and addressing community priorities;
- development of community ownership;
- the collection of appropriate data; and
- the development of effective partnerships with external groups, which have a role to play in enhancing the capacity of the community to address the problem.

They also note that interventions tested in one context do not necessarily work in another.

CASE STUDY 5 — Yarrabah Men's Health Group Project

Name of project
Yarrabah Men's Health Group Project.

Brief description of project/program
The Yarrabah Men's Health Group Project involves support and education around suicide prevention as well as strategic planning workshops. The aim of the project is to help build the capacity of men to participate in community activities.

Name of organisation conducting the project
Gurriny Yealamucka Health Service Aboriginal Corporation

Description of organisation
Gurriny Yealamucka ("good healing water") Health Service Aboriginal Corporation is the local Aboriginal community-controlled health service. It commenced on 1 October 2001. The core business of Gurriny Yealamucka is to provide a culturally-sensitive multipurpose primary health care service and to implement the Yarrabah health framework agreement in partnership with Queensland Health, Yarrabah Community Council and Commonwealth Department of Health and Ageing.

Type of intervention
Education, support, men's groups, strategic planning, community development

Injury problem being addressed
Suicide prevention, self-harm, domestic violence

Dates of project
Yarrabah Men's Health Group Project has been operating since late 2001.

Phase
The project is currently in its second year of a two-year pilot project.

Scope
Local project

Geographic location
Yarrabah community, Queensland

Target population
Indigenous men living in Yarrabah

Funding body
Commonwealth Department of Health and Ageing

OATSIHS

Partnerships
The project is a pilot project between Gurriny Yealamucka Health Service Aboriginal Corporation and the Commonwealth Department of Health and Ageing.

The project works in partnerships with other groups, including: State Department of Corrections; Wuchoperon Health Service, Cairns (Aboriginal community-controlled health service); the Justice Group; and the Women's Resource Centre.

Under a recently funded community development project, the Partnership for Health Project, a formal partnership agreement has been set up by the Yarrabah community, which integrates all primary health care services. The Yarrabah Men's Health Group Project is part of this larger project. The key stakeholders for the three-year Partnership for Health Project are: Gurriny Yealamucka Health Service Aboriginal Corporation; Yarrabah Community Council; University of Queensland; and the pharmaceutical company GlaxoSmithKline.

Linkages have been formed with 21 other government and non-government organisations.

Other sources of information available about the project

David Patterson — <david@gyhsac.org.au>

Yarrabah Men's Health Group. Video produced by Apunipima Cape York Health Council.

Gurriny Yealamucka Health Service (25 September 2002) Yarrabah Men's Health Group — 12 months Progress Report: A Gurriny Yealamucka Men's Health Initiative sponsored by the Commonwealth Department of Health and Ageing.

Yarrabah Health Framework Agreement

Many Ways — One Way

Yarrabah Health Action plan

<http://www.Yarrabahonline.org>

Tsey K, Patterson D, Whiteside M, Baird L, Baird B 2002 'Indigenous men taking their rightful place in society? A participatory action research process with Yarrabah Men's Health Group', *Australian Journal of Rural Health*, 10(6): 278–284.

Future directions

The Yarrabah Men's Health Group Project is part of a larger move towards self-determination taking place within Yarrabah. It builds on sustained work in community health and community development by local community members and partnerships, which has been going on since the 1980s. It is expected that the medical service will seek further funds when the present funding for the Yarrabah Men's Health Group Project runs out. The men's group is also looking at becoming incorporated so that they can fund themselves.

Background

Data has been collected in Yarrabah since June 1998 to determine the burden of injury-related conditions on the health service and to identify the major underlying causes that need to be addressed to prevent injury in the community. Dr Robyn McDermott, Clinical Epidemiologist at Tropical Public Health Unit, has compiled information on health status for Yarrabah (see <http://www.Yarrabahonline.org>). It is thought that the domestic violence reported in Yarrabah is much lower than the true amount of domestic violence really occurring. The injury data from Yarrabah confirms that the pattern reported is similar to that seen in Cape York communities (Gladman, D.J. et al 1997) and that a significant amount of health resources is expended on conditions that are preventable.

The Yarrabah Men's Health Group Project grew out of an earlier community-based project, the Family life Promotion Project *(*See Case Study 19 in this volume).

During the early 1990s the Yarrabah community went through a period of high suicides, which led the community to seek solutions. The deceased were mostly male and it appeared that the suicides were related to relationship problems, high incarceration rates, peer pressure and the lack of expression of feelings by men. There was no support group in place at the time. Members of the community applied for funds to the Queensland Health Department to establish a program to prevent further suicides. The Family Life Promotion Program was established in 1995. This program is currently operating and is staffed by 2 workers.

In 1997–8 a feasibility study was done and gaps in services were identified — particularly in the area of socio-emotional wellbeing. As a result of this work over many years a Socio-emotional and Spiritual Well-being Centre of Excellence was established, and a number of services set up to address many of the 'stolen generation' issues such as dispossession, alienation and intergenerational trauma, which were affecting Yarrabah families.

The Yarrabah Men's Health Group pilot project has extended the earlier suicide prevention initiatives in Yarrabah to a community-based activity that supports and promotes the social and emotional wellbeing of men.

The objective of the men's group is to restore men's rightful role in the community using a holistic healing approach encompassing, in a program, the spiritual, mental, physical, emotional and social aspects of life.

The Men's health program is one of the objectives of the new Partnership for Health project, which integrates primary health care services. It is one of a number of targeted primary health care programs, set up to facilitate community healing.[E] Strategies have been developed and are part of the Yarrabah Health Action Plan.

Interview

A site visit was undertaken to Cairns and Yarrabah. Face-to-face interviews were carried out with: Mr Les Baird, Health Manager, Gurriny Yealamucka; and Mr David Patterson, Men's Coordinator, Gurriny Yealamucka.

David Patterson, Men's Coordinator, began working with the Family Life Promotion project in Yarrabah from 1997 to early 2001. The Commonwealth Department of Health and Ageing funded a Men's Coordinator (August 2001). Previously the men's group was a voluntary program. The Yarrabah Men's Health Group Project is currently in its second year of a 2-year pilot.

The Yarrabah Men's Health Group Project involves support and education around suicide prevention as well as strategic planning workshops. The aim of the project is to help build the capacity of men to participate in community activities. It does this by engaging Yarrabah men in issues related to their health and their role in the family By enabling men to better participate in other community initiatives, it has a community-wide health benefit.

The project has five key foci:

- leadership and parenting;
- tradition and culture, including a cultural dance group — the focus is on identity and pride.
- education and training;
- employment, including small business proposals — a feasibility study is to be undertaken for a men's group business plan; and
- the men's shelter — Yubba Bimbie Place.

[E] The other services are Women's Health Program, Family and Child Health, Family Well-Being Leadership Training Program, and Alcohol and Drug Program.

Work is currently taking place on all 5 strategies. The business plan is being developed and a landscaping business planned. The strategy is to create employment rather than rely on the 2 days in the CDEP. Arts, crafts and furniture are being made and sold, and work is being done on bush medicines. The cultural dance troupe has been active for some time.

Other aspects of the project include:

- important work on self-esteem;
- a men's health clinic one day a week, conducted by an Indigenous doctor; and
- the coordinator also goes to the courts and provides character references to the magistrates — probation offers include mandated attendance at the men's group.

The project works in partnerships with other groups including: University of Queensland; Department of Corrections; Wuchoperon Health Service, Cairns; the Justice Group; and the Women's Resource Centre.

Around 40–50 men come to the men's group each month. Of these, 2-3 are offenders. The first meeting was in 1998, and it was attended by about 20 men. Men find out about the project through word of mouth. Support groups mostly involve talking but also hunting, fishing and social activities (restaurants etc) Attendance at the program is voluntary for most participants (a small number of men are sent by the courts). Most of the men are in their 20s, and come in seek of help. They have the support of a young co-worker (Mr Bradley Baird) who can relate to young men. A major focus of the men's group is on relationships. A concern has been raised about the men's group being gay friendly, and this is being addressed.

What difference has the project made?

> Men have more knowledge about issues;
>
> They are able to think about actions;
>
> Women see men's group as good;
>
> Pride in place for healing, and increased capacity for men to participate in family and community life; and
>
> Changes in attitudes are occurring, particularly around the role of men in the family.

According to David Patterson, the key to success has been the strategic planning workshop. The health service has worked closely with the University of Queensland (Komla Tsey and Mary Whiteside) to reduce injuries from domestic violence and reduce self-harm. The university, through Professor Ernest Hunter, has also been instrumental in obtaining corporate funds for Yarrabah initiatives.

Evaluation

Police statistics show that there has been a 2% decrease in domestic violence from 2001–2. However, there is a need for a formal evaluation of the project. The University of Queensland and the men's group project team have developed an evaluation framework using participatory action research (PAR), and are involved the collection of qualitative and quantitative data. The PAR process is intended to empower men to be involved in their own research and make changes. The evaluation has not yet occurred.

There is also a plan to report on statistics — for example, the number of men attending the men's group; and the number of suicide attempts — in the next quarterly report to the Commonwealth.

Resource development

A men's group video has been developed, as well as pamphlets and posters.

Other activities

At present, the Yarrabah community also has a women' health project to work on implementing the Women's Health Strategy and the Family and Child Health Strategy. This is a one-year project funded by the Ian Potter Foundation and the Yarrabah Council CDEP program.

The Family Well-Being Leadership Training Project has also been funded by FaCS under the Stronger Families and Communities Strategy. The model was developed in Adelaide — at the Aboriginal Education Unit — and involves personal healing and leadership, human needs, and dealing with crises and relationships. Gurriny Yealamucka Health Service Aboriginal Corporation will employ a project officer for this project, which is meant to provide family wellbeing leadership training to a group of men and women in Yarrabah to take greater responsibility for health and wellbeing and support the wider community.

The community also has an Alcohol and Drug Program, a Public Health Nutrition Program, and an Environmental health initiative. A recent initiative is the Yarrabah touch-screen and Yarrabah online website, which disseminate health information and information on the community developments taking place in Yarrabah.

CASE STUDY 6 — Fixing Houses For Better Health

Name of project
Fixing Houses for Better Health (FHBH)

Brief description of project/program
Fixing Houses for Better Health 1 (FHBH1) aimed at fixing 1000 Indigenous houses nationally. The two key areas were safety and health.

Name of organisation conducting the project
Healthabitat

Description of organisation
Healthabitat is a private company whose main activity concerns improving physical living conditions to improve health.

Type of intervention
Housing safety

Injury problem being addressed
Injury problems being addressed were: electrical safety, gas safety, fire safety; and any safety issues relating to structural collapse (eg. stairs, handrails) and burns from hot water.

Dates of project
1999–2000

Phase
Ongoing

Scope
National project

Geographic location
Australia-wide

Target population
Indigenous communities

Funding body
Fixing Houses for Better Health 1 was funded by ATSIC — Fixing Houses for Better Health 2 was funded by the Department of Family and Community Services (FACS).

Partnerships
All State/Territory Indigenous Housing agencies

State/Territory ATSIC offices

Each project community

Health departments in some states

Other sources of information available about the project
NSW Drug and Alcohol Project Database

Future directions

Fixing Houses for Better Health 3 and 4 (2003–2005)

Background

The Fixing Houses for Better Health 1 project addressed the issue of housing conditions in Indigenous communities. Historically, Aboriginal housing has performed poorly in the areas of safety and health. The Fixing Houses for Better Health 1 project specifically involved careful inspection of 1000 houses and immediate fix work and subsequent modifications to improve key areas of safety and health. It was initiated by Healthabitat as part their ongoing work and was based on their knowledge of the historical perspective as well as 15 years of similar work, including constantly refining and revising information based on personal experience and the experience of others in the field. Healthabitat worked in association with the federal and State/Territory ATSIC bodies, the State/Territory Indigenous housing agencies, and various participating communities. They delivered the project nationally and reported back to ATSIC.

Interview

This report is based on an interview with Paul Pholeros, National Program Manager, Fixing Houses for Better Health.

Collection of data was seen as a critical part of the project: firstly, because it enables immediate fix work to be carried out; it informs targets for new projects; and, finally, "hard data" (quantitative data) can be used to convince agencies — like ATSIC and housing and health providers — that the work is needed, and to document what has been achieved.

The injury problem was well understood by the project coordinators of Fixing Houses for Better Health. Injuries associated with the housing often include injuries to children. Scalding, particularly in young children, can be caused by faulty temperature-monitoring devices (thermostats or in some newer houses tempering valves) on hot water systems. This means water comes out of hot water taps at unsafe temperatures. The low capacity of hot water systems for the number of household residents can result in the system's temperatures being turned up to unsafe levels in an attempt to compensate for the inadequate hot water supply. There are multiplicities of interacting factors that increase the risk of fire in the houses of Aboriginal people. Electrical and burns injuries can be caused by: vermin damage to electrical cabling; the inability to pay power costs (when, for example, candles are used and cause fires); the lack of smoke detection equipment; overcrowding and lack of access and egress (for example, insect screens screwed to windows preventing escape).

Management and staff, planning, budgeting

The project was funded federally by ATSIC. To operate the project required both the human and physical resources to assess 1000 houses and immediately fix a range of faults. Included were licensed tradespeople — plumbers, electrician, carpenters, etc. Other people involved in the project were 5 Area managers, 5 State Managers and 273 local Aboriginal staff. On a day-to-day basis, the Area Managers provided the resources with the overall backing of ATSIC. The methodology involved training and employing local community people on prioritised survey/fix work.

Outcomes

How successful was the intervention?

> The project has been successful, with a qualifier: the limited budget impacts on the outcomes possible to achieve. The "hard data" shows improvements in various aspects of the houses related to safety and health. Houses were demonstrably (data) safer and healthier after the project.

What improvements have occurred as a result?

> The data shows that, for 792 of the houses surveyed and fixed: safe electrical systems improved from 13% to 64%; gas safety improved from 69% to 75%; structure and access improved from 43% to 46%; and fire safety improved from 3% to 16%.

Has it prevented or reduced injury? To what extent?

> As to whether it has prevented or reduced injury, this is impossible to determine. There was no base line data available. Even if this data was available, confounding factors would make it difficult to interpret.

Would the results have happened anyhow?

> No, absolutely not.

Did the intervention reach all who might have benefited?

> Yes — every family in every house in every community involved.

Would the intervention have helped elsewhere, in different circumstances, or in a different community?

> Yes, hence the follow up project FHBH 2. It can be done anywhere. It is unlikely that any community has perfect housing. Any community would benefit from using the methodology to check their housing.

Evaluation

Was the project monitored and evaluated?

> ATSIC did an evaluation, using both qualitative and quantitative data. An internal monitoring process occurs during the project. A second survey, which also includes a small fix component, repeats the same survey process conducted at the beginning of the project. This can be used to compare the condition of all houses before and after the fix work is done, and is a key point of the methodology.

What were the negatives?

> Lack of resources. The budget was insufficient to rectify major safety problems due to the very poor quality of some of the houses (only 13% of houses were found to be electrically safe).

Who benefited the least?

> There was no group who missed out in the communities visited.

How did the community view the intervention/project? Was it acceptable?

> Although there is no hard data to indicate the level of acceptance, there was an overall positive view of the project from the participating communities. And access to all houses was okay, indicative of a positive response.

Could it have been done differently?

> Yes. Each time a project runs, the methodology is improved based on feedback. As a result of feedback from this FHBH1 project, the next round of projects has: more money allocated per house; improved reporting from the tradespeople; individual reports provided to each household on the condition of their house (as opposed to the report of all houses).

Who benefited the most from the intervention?

> From a medical viewpoint, the core interventions are aimed at children 0–5. However, the quantitative data doesn't provide evidence of this. The benefits would be spread on an equitable basis between all the households.

Who benefited least?

> Not really applicable, as all households receive benefits.

In your opinion was it cost-effective?

> Compared to what? There is no similar project to make comparisons, but this is an important point and should be considered in any intervention

Could it be replicated in another community?

> Yes, and it has, both previous to and since FHBH1.

What was your experience of the intervention/project?

> At the local community level, it has been a very positive experience. At the State level, it has been the least positive — due to a lack of support from some States. The level of detail needed to achieve results is not supported by many agencies wanting a major fix solution.

Recommendations to prevent injuries
Increase resources

Have better links with what is learned from projects and the development of design

Enable the information obtained to have a far greater influence at the State level to prevent a repeat of the same mistakes in Aboriginal housing design and construction.

CASE STUDY 7 — Shoalhaven Injury Surveillance and Prevention Project

Name of project
Shoalhaven Injury Surveillance and Prevention Project

Brief description of project/program
The Shoalhaven Injury Surveillance and Prevention Project is one of two pilot projects in NSW funded by the Commonwealth Department of Health and Community Services, and supported and administered through the Injury Prevention Policy Unit of NSW Health. Phase 1 of this project aimed to describe injury patterns and subsequent 'risk factors' among Indigenous people living in the Shoalhaven region on the South Coast of NSW, and to identify opportunities in which local Indigenous communities can use this information to plan injury prevention strategies.

Name of organisation conducting the project
Illawarra Area Health Service, NSW Health

South Coast Aboriginal Medical Service

Description of organisation
Illawarra Area Health Service, NSW Health (government organisation)

South Coast Aboriginal Medical Service (Indigenous community-controlled health organisation)

Type of intervention
Injury surveillance

Injury problem being addressed
All Injuries

Dates of project
November 1999 (project manager appointed) to August 2001 (report published)

Phase
The surveillance phase (phase 1) of the project has been completed and reported on. Phase 2, the implementation stage of the project, has not yet occurred.

Scope
Regional project

Geographic location
Shoalhaven region, NSW

Target population
Indigenous population

Funding body
Funded by the Commonwealth Department of Health and Community Services with further support provided by NSW Health's Injury Prevention Policy Unit

Partnerships
The project was managed locally through the Illawarra Area Health Service, subject to a funding agreement between IAHS and NSW Health. It was also supported through the Shoalhaven Aboriginal Health Partnership, a partnership of service providers in the Shoalhaven, involving local Aboriginal community-controlled health organisations in the Illawarra Area Health Service.

Other sources of information available about the project

Royal, T. (2000) *Shoalhaven Injury Surveillance and Prevention Strategy Stage 1* NSW Health Monograph, Nowra.

Future directions

The Shoalhaven Injury Surveillance and Prevention Project Phase 1 Report outlines the findings of phase 1 and the vision for the future of the project.

Background

Even though Indigenous status is under-reported in NSW, injury-related hospital data were still twice as common among Indigenous people in NSW. Little data exists which describes the injury experience of Indigenous people in Aboriginal communities in NSW. This project replicated some of the methods of the Cape York project (Gladman et al. 1997). The project used both quantitative and qualitative methodologies. It collected routine hospital data and emergency department case data as well as in-depth qualitative data from semi-structured interviews, event narrative interviews and focus group discussions to find out more about Indigenous people's experiences of injury in the Shoalhaven.

Interview

A site visit was undertaken at Nowra. Mr Tim Royal, Injury Project Manager and Case Worker at the South Coast Medical Service Aboriginal Corporation, was interviewed.

What do you understand by the term 'injury'?

> 'Injury' is any physical, psychological damage to wellbeing. This also includes accidental. All injuries that occur in mainstream also occur in Indigenous communities. These rates differ from mainstream and Indigenous. There are higher rates in Indigenous injuries related to interpersonal injury, sporting injury and home-based 0–4 year olds.

What do you think is the best approach for dealing with injuries in Indigenous communities?

> There should be a no-blame type of approach and it should have a positive outcome. It should be community based rather than government (top down). This should include raising awareness to get community awareness and a collaborative approach (with other stakeholders).

Have you seen any programs or interventions that work to improve this situation?

> Yes, several, KidSafe, Indigenous injury prevention strategy. Mainstream awareness for the carers of children, for example, water safety.

Describe the nature of injuries, which occur in the community in which you live or work or know about?

> Sprains and strains, fractures, burns, lacerations, animal bites (dog bites), psychological injuries should be included in collaboration with physical injuries.

Describe an injury in a specific or local context?

> There was a fire in one of the Aboriginal communities in the Nowra/Shoalhaven area. In this fire, there was a fatality. There were lots of people affected. This was written up as a case study for this report (Shoalhaven injury prevention and surveillance plan). This injury had several factors. The deceased had been drinking alcohol and had fallen asleep. At the time when he had fallen asleep, he had been smoking which had started the fire. He was too intoxicated to realise that a fire had started. There were no fire alarm detectors.

What could have been done to help prevent this type of injury?

> There could have been a fire safety inspection on a regular basis, installation of a fire alarm, fire extinguisher and smoke detectors. (A cut-off switch could have been fitted to the premises in order to stop electrical shorts leading to fires.) There could have been some drug and alcohol education for the Indigenous community. The deceased had been to a funeral earlier. It was his son's funeral. The whole family was overcome with grief and were consuming alcohol on the night of the fire. There could have been a harm minimisation program, which is an alternative to total abstinence or drug and alcohol. Harm minimisation accepts the fact that people do use drugs and alcohol. Within this harm minimisation program ,there is a buddy system. If you drink, someone drives you home. (This is a preventive strategy.) …
>
> There were no follow-ups for the people in the community. They were shaken up by the fire. There are still some unresolved issues. Some of the people did not receive the relevant counselling to combat this grief. In a strange way it has raised awareness of injury prevention for the community. This highlighted the awareness of practical fire safety. This fire prompted recommendations for the follow-up of education in relation to alcohol and also for safety audits in houses in this community.

Can you give me an example of another case study?

> Yes. Domestic violence to women needs to be addressed. Workshops and other strategies need to be implemented. People skills for dealing with domestic conflict. Domestic violence is a national crisis. There are so many in the community.
>
> There is an example of a case where the male partner had returned home after drinking alcohol. An argument had occurred and the male partner had assaulted the female. The female did not report this to the police or medical personnel. She had cheekbone bruises and fractures to the face. This is not uncommon in Indigenous communities. (Reporting the incident)

Due to fear of partner and the consequences of reporting the injury, she didn't report this incident?

> Cultural issues. The community often protects the perpetrator. The community quietly closes up and does not talk about the domestic violence. Domestic violence is then understated in the statistics because it is not being reported.

How do you think injuries among Indigenous people (in your area) can be reduced?

> There is no one solution, but raising awareness is important. This needs to be a community-based initiative not a government bandaid treatment. There should also be school-based education for the young parents, empowering them to give skills in raising children.

Is the prevention of injuries a priority for this community?

> Yes. (Where people are having trouble, unfortunately, they do not realise how high these health indicators are for the Indigenous communities.) When these Indigenous people sustain an injury, often a ripple effect occurs. For example, if a football injury occurs where a man breaks his arm, he is unable to work; therefore he loses his job; and then they get depressed and they turn to alcohol and/or drug abuse. This ripple affect is not properly acknowledged by the community.

What should be done to address these problems?

> The approach must include the whole community. Ownership of the approach should be community controlled. Strategies should be community based and should also have a joint partnership between mainstream and Koori agencies involved. There needs to be an awareness of the impact of all sectors of society not just the health sector — for example, the police.

What role do Aboriginal health workers currently play in preventing injuries? And are they prepared enough?

> They have a two-way role. They have to report to/feed back to government. In the process of feeding back, something is lost. This is very important — that the Aboriginal health workers are involved. These Aboriginal health workers have more awareness of other aspects of health issues. They are the key people in liaising between the community and the various governing bodies. The Aboriginal health workers receive education about the issues and then they share it with the community members.

You were involved with phase 1, could you tell me the position of phases 2, 3 etc?

> Phase 2 is being implemented at the moment. It has been employed through the funding from phase 1. At the moment they are still identifying key areas for phase 2. Several recommendations have been implemented but at this stage the heavier recommendations have not. We are still looking to adopt them. Through phase 2, we are looking to declare the Shoalhaven an Indigenous safe community. (To his knowledge no other Indigenous community has done this previously.) Phase two will be addressing issues such as domestic violence injury, interpersonal injury and child injury. (Other agencies are needed to help within these areas — conflict resolution.)
>
> It will also look at health factors in the health and living environment in the housing. They have already done this in Jerrinja (an Aboriginal community in the Shoalhaven).

Mr Royal recommended that this happen across the board, not just one community:

> There is an issue that has arisen. This issue involves the access of health services in the Shoalhaven by Indigenous people. There needs to be education for the Indigenous people on how to use these agencies. Illawarra health has raised their profile because there is a lack of Indigenous people using their services.

How successful was the intervention?

> This is a partial success. There needs to be hard data to see if the statistics have improved. Community consultation needs to be done in order to find out if they are more aware of injury prevention in the community. There needs to be a safety audit by going into houses and identifying potential risks. Major issues include drug -and alcohol-related injuries. Because of historical factors, lots of members of the Indigenous community have low self-esteem and are prone to alcohol and drug issues. It is an individual effect, but overall the people think that there is a barrier that holds them back. Learnt behaviour — young kids witness parents behaviour and this leads an example. For example, if a young kid sees his father hit his mother, he will think that it is normal to do this. The child will then grow up and do as his father has. This chain needs to be broken. Cultural groups need to be told that these barriers can be broken. Incarceration rates and murder rates, assault rates need to be reduced. This would give a message of positive self-worth.

How did the community view the intervention?

> Universally, community members stated that drug and alcohol were the worst. A minority of the community members made the link between drug and alcohol abuse and the underlying factors/issues. The community members viewed the cultural issues as a factor. The removal of cultural functions within family's which has occurred over time, (Assimilation and dispossession) has lead to the loss of identity of Aboriginal men which is related to drug and alcohol abuse. This leads to injury.

Was it cost-effective?

> If one person's life is saved, then it is worth it. As with most of these projects, the bulk of the funding is used for wages.

Could it be replicated in another community?

> Yes, although it needs to be fine-tuned to cater for individual purposes. For example, I have not seen any cases of petrol sniffing in the Nowra/Shoalhaven area. Therefore this issue was not addressed. This may not be effective in Central Australia. Globally, this needs to be improved.

How would you get other community members involved in injury prevention activities?

> Firstly, if the community members are interested, then they should be trained up. They should be consulted to target specific issues within the community. They should then run with the recommendation. Employing full-time Aboriginal community safety officers. (New position to be created). Training components. Employ environmental safety officers (these are not quite building inspectors). Training the community members to identify potential injury risks in the home — for example, storing all the dangerous chemicals in a position that a toddler cannot reach.

Is there anything you would do to prevent injuries that you think hasn't been done already?

> Plenty. Focus on: school-based education; educating young people; more Indigenous campaigns — not just pamphlets, but also through media — short films, educational films and promoting health through electronic media. Don't get outside actors, you should have Shoalhaven Indigenous people act in them.

Outcomes

Several short- and long-term priority areas for action were identified during the project, based on the information obtained for this project, including from extensive community consultations — specific injury related risks and risk groups, namely:

- home-based injuries, particularly among children;
- leisure and sports injuries, particularly among 10- to 25-year-olds;
- drug- and alcohol-related injuries particularly among 15- to 35-year-old males;
- injuries resulting form interpersonal violence and self-harm;
- work-related injuries;
- positive development of individual, community and cultural identity;
- access to health and community services; and
- Indigenous injury surveillance.

Recommendations

Recommended actions from the project are:

- address specific injury risks and risk groups, such as through creating safe home environments;
- improve access to services;
- develop the infrastructure in existing Indigenous communities to develop, support and sustain community-based injury prevention strategies;
- establish a Shoalhaven Safe Indigenous Communities Initiative, based on community involvement, ownership and control;
- create community-based training and employment opportunities, through the establishment of an Indigenous Community Safety Officer Program; and
- improve injury surveillance systems to enable ongoing identification of injury patterns and risk factors.

CASE STUDY 8 — Tangentyere Remote Area Night Patrol

Name of project
Tangentyere Remote Area Night Patrol

Brief description of project/program
Tangentyere means "working together". The goal of this project is to improve support for Aboriginal people in Alice Springs. Through providing coordinated and resourced assistance, it is ultimately hoped that violence and related crime will be reduced/prevented. The project is a community-based night patrol servicing the Aboriginal peoples of Alice Springs. The night patrol provides a buffer of trained Aboriginal support workers for the local Aboriginal community as per the recommendations of the Royal Commission Inquiry into Aboriginal Deaths in Custody (1991). It primarily supports the 18 Aboriginal town lease communities in Alice Springs, but also patrols the major community centres of Alice Springs and crime 'hot spots'. Logistical support is given to the local drying out shelter, women's shelter, hospital, youth emergency accommodations services, alcohol rehabilitation projects and police. In addition, the patrol helps with dispute resolution, lost children, medical and numerous other emergencies. The night patrol is on call from 5pm to midnight every night except Sunday.

Royal Commission into Aboriginal Deaths in Custody. (1991). *Royal Commission into Aboriginal Deaths in Custody. Final report.* Canberra: Australian Government Publishing Service.

Name of organisation conducting the project
Tangentyere Council Inc

Description of organisation
Local Aboriginal community-controlled organisation. The Tangentyere ("Working together") Council, is made up of three representatives from every town camp. (There are 18 town camps and each has a separate incorporated body with their own committee. Three people from each of these committees sit on the Tangentyere Council. The council is a resource agency and service broker). The services provided are decided by the needs of the local community.

Type of intervention
Night patrol

Preventative injury services

Injury problem being addressed
Alcohol and violence, family violence

Dates of project
Project commenced 1993

Phase
Ongoing

Scope
Regional project

Geographic location
Alice Springs area, out to eastern WA, the Top End of NT and northern SA

Target population
Remote Indigenous communities

Funding body
ATSIC

Other sources of information available about the project
Tangentyere Council <http://www.westnet.com.au/yamaji/indig_info/Tangentyere.html>

Phone 08 89514227

Fax 0889528521

<research@tangentyere.org.au>

Future directions
The project is ongoing.

Background
See Walker, Jenny and Forrester, Sharron. (2002) 'Tangentyere Remote Area Night Patrol' Paper presented at the Crime Prevention Conference convened by the Australian Institute of Criminology and the Crime Prevention Branch, Commonwealth Attorney-General's Department in Sydney 12–13 September.

Interview
A phone interview was conducted with Sharron Forrester.

The Tangentyere (means "working together") Night Patrol patrols the town camps, the CBD and goes out to some urban calls. It operates out of Alice Springs, using two vehicular patrols with radio communication back to base, and provides other support services:

> Works like a police force but without arresting powers. It provides a range of preventative injury services. It administers emergency relief, food, and tries to get permanent placements for people rather than just place in temporary situations. It covers 2000 km^2 of territory — from Alice area, out to east WA, Top end of NT, north SA. Alice is the major service centre for health and social services.

Tangentyere Night Patrol provides a range of preventive injury services including: relocating families from situations they don't want to be in; providing transport for people to get to and from hospital; relocating families from situations they don't want to be in; providing transport for people to get to and from hospital; providing transport for kids stranded in town and taking them to a safe place to stay; picking up people who are drunk and taking them to stay with a family member rather then leaving them lying in the street or taking them to a sobering up shelter. Anything in the "too hard basket" (Walker and Forrester 2002):

> '. . . people become economically trapped in Alice and end up in cycles of grog use and abuse. Tangentyere Night Patrol responds to the various crises that arise from this. Alice Springs is not a designated dry area. Expectations are high, and resources always lag behind need'.

The night patrol deals with the police, and acts as mediator. There are speakers of the different local languages in the patrol to interpret. Language is a big barrier as English is often the second, third or fourth language for some town people. It also acts as a referral service linking people up with other services. The patrol has a good relationship with other services and there is a lot of client crossover. Other services provide back up and fill the gaps:

> The whole organisation is preventative.

The night patrol prevents anything from family/domestic violence to death and alcohol-related injuries. It was introduced because the police were reluctant to go into the town camps. Male and female community members from the town camps initiated the project. They started doing a volunteer community patrol and covered all the language groups of Central Australia. Then they sought funding from ATSIC. It didn't fit into any box or funding category easily. ATSIC currently funds the project.

Sharon Forrester, the coordinator of social justice programs, currently oversees the day and night patrol, the warden program, and return people to country program. This work involves getting people to the meeting of the 4 Corners Council (council of elders) and carrying out what the council decides.

According to Ms Forrester the project has been very successful:

> It has definitely prevented injury. It diffuses problems and provides support. When the service does not run, the night patrol is inundated with calls.
>
> If it's taken away for one night, it is clear how necessary the service is.
>
> We encourage Indigenous organisations across Australia to come and look at what we're doing. We get visits from people on how to use our model for their own place. A group from Townsville visited to see how to organise their services — they have a large transient population, a similar situation to Alice Springs — a group of people have come over twice and the coordinator came and spent a week here with us. We also get a lot of groups from unis.
>
> The night patrol is expensive to run but it's good value. If we took the organisation away tomorrow, there would be a huge cost to the community in terms of the burden it would put on other services.

The project has to report regularly to ATSIC. Also a database keeps a record of all the incidents, every contact:

> We're filling in the gaps from local services that are not culturally appropriate. There wouldn't be such a need for us if there was more culturally-appropriate services. They are not accessible or user friendly for Aboriginal people. Poverty is a huge problem — there is still a large number of people with no income — it's too intimidating to go into the office. There's a lot of stress, particularly on family members who are the only income earner. People are stuck in the 'revolving door": they get a benefit then get cut off, stay off for a while then reapply.
>
> There is still a lot of prejudice in town, and Aboriginal people are treated with intolerance, suspicion, fear etc. White households ring up the patrol to pick up people if they are sitting outside on the verge — even if they are not causing a problem, or may be visiting someone over the road.

Community acceptability

According to Ms Forrester, the project is acceptable to the community because the community/clients are the bosses. The services provided are decided by their needs and are culturally appropriate. The night patrol is responsible to the Tangentyere ("working together") Council, which is made up of three representatives from every town camp. There are 18 town camps and each has a separate incorporated body with their own committee. Three people from each of these committees sit on the Tangentyere. Council. The council is a resource agency and service broker (Walker and Forrester 2002):

> 'Night patrols are an Aboriginal idea. They are based on and come from the Aboriginal people living in the community. This is why they work. There are marked differences in cultural attitudes between whitefellas and Aboriginal peoples. Aboriginal law most closely resembles what whitefellas would call restorative justice. Night patrols perform a huge range of functions, according to the needs of their communities and the resources they have available. They act as a nexus to connect people and services such as clinics, courts, Police, community government councils, and family. They mediate disputes, remove people from danger, keep the peace at events such as sports carnivals, are consulted by agencies such as courts for input into sentencing, and play a crucial role in the development of community justice systems'.

CASE STUDY 9 — WA Water safety projects:

Name of projects
Drowning Prevention Program for Aboriginal Health Workers throughout Rural and Remote Western Australia

Remote Aboriginal Swimming Pools Project

Drowning Prevention Project

Brief description of projects
The Drowning Prevention Program for Aboriginal Health Workers throughout Rural and Remote Western Australia project focused on equipping Aboriginal Health Workers with skills and knowledge to educate community members on drowning prevention strategies.

The Remote Aboriginal Swimming Pools Project was part of a state government Department of Housing and Works environmental health intervention. It involved the building of swimming pools in three remote Aboriginal communities of Western Australia, teaching the children water safety skills and training other community members in swimming and lifesaving techniques.

The Drowning Prevention Project is a new, Healthway funded project due to commence in February 2003. The purpose of the program is to introduce the Royal Life Saving Society's Swim and Survive program within the Aboriginal and culturally- and linguistically-diverse groups in Western Australia.

Name of organisation conducting the project
Royal Life Saving Society WA Branch

Description of organisation
Royal Life Saving's mission is to prevent the loss of life and injury in the community with emphasis on aquatic environments.

Type of intervention
Drowning safety, education, community development

Injury problem being addressed
Preventing drowning and promoting safety in remote Aboriginal communities

Dates of project
Drowning Prevention Program for Aboriginal Health Workers throughout Rural and Remote Western Australia — 2000

Remote Aboriginal Swimming Pools Project (2000–2003) commenced July 2000

Drowning Prevention Project to commence early 2003

Phase
Drowning Prevention Program for Aboriginal Health Workers throughout Rural and Remote Western Australia — project completed

Remote Aboriginal Swimming Pools Project — ongoing

Drowning Prevention Project — not yet commenced

Scope
Regional and local projects

Geographic location
Remote areas of Western Australia

Target population
Indigenous people in remote areas of Western Australia

Funding body
Drowning Prevention Program for Aboriginal Health Workers throughout Rural and Remote Western Australia is funded by Commonwealth of Health and Aged Care's RHSET Program.

Remote Aboriginal Swimming Pools Project is funded by the Department of Housing & Works.

Drowning Prevention Project is funded by Healthway (Health Promotion Foundation of WA).

Partnerships
Marr Mooditj Aboriginal Health Worker College

Other sources of information available about the project
Marilyn Lyford, Health Promotion Coordinator, the Royal Life Saving Society Australia (WA Branch), PO Box 28 Floreat Forum, WA 6014

Telephone: (08) 9383 9988

Fax: (08) 9383 9922

E-mail: <mlyford@rlsswa.com.au>

Lyford, M. (2000) *Drowning Prevention Program for Aboriginal Health Workers throughout Rural and Remote Western Australia*. Final Report Rural Health Support, Education and Training (RHSET) Program Grant number 99580A The Commonwealth Department of Health and Aged Care

Lyford, M. (2001) *Enhancing Community Health in Remote Aboriginal Communities* Preventing drownings and promoting safety in remote Aboriginal communities. Royal Life Saving Society (WA Branch) PO Box 28 Floreat Forum WA 6014.

Video — Watch Out for the Kids! *Indigenous Health Promotion Resources* 4th edition, Aboriginal and Islander Health Worker Journal.

Future directions
A new project, Drowning Prevention Project, funded by Healthway (Health Promotion Foundation of WA) is due to commence in February2003

Background

Drowning Prevention Program for Aboriginal Health Workers throughout Rural and Remote Western Australia

This project focused on equipping Aboriginal Health Workers with skills and knowledge to educate community members on drowning prevention strategies. An injury prevention module was developed and presented to health workers attending the Marr Mooditj Aboriginal Health Worker College in Perth and regional towns. The Commonwealth Department of Health and Aged Care's RHSET Program funded the project.

A drowning prevention video was developed in collaboration with staff and students, and disseminated to rural and remote communities.

After consultation with a number of key people involved in education for Aboriginal health workers, an injury prevention module was developed for inclusion in the health workers' training program. This module formed the basis of the workshops. The workshops were conducted over a three-hour period, and a post-workshop questionnaire was administered. Over 50 health workers from communities throughout the state attended the workshops.

Workshops were conducted at the Marr Mooditj Training College, the regional centre of Kalgoorlie and the remote community of Warburton. These workshops formed part of the teaching program for health workers. Due to a number of external factors, the planned workshop at Broome was cancelled.

Evaluation

The evaluation at the conclusion of the workshops was positive. It showed that the students were more confident in talking to clients and other community members about preventing injuries in their community, and found the workshop content and presentation relevant and appropriate to their needs.

Outcome

The outcome of this project is that Ms Lyford guest lectures at Marr Mooditj to their Certificate 3 students in primary health care (once or twice a year). She is also addressing the need for a specific injury prevention course. At the moment, the first aid component is the extent of injury prevention in the curriculum.

Remote Aboriginal Swimming Pools Project

The Remote Aboriginal Swimming Pools Project conducted by the Royal Life Saving WA was not a specific injury prevention program:

> Our management includes teaching the children water safety skills and also to train other community members in swimming and lifesaving techniques.

The project was part of a state government Department of Housing and Works environmental health intervention. Swimming pools were built in the remote Aboriginal communities of Burringurrah, Jigalong and Yandeyarra in Western Australia. The Royal Life Saving Society is managing the aquatic facilities for three years (2000–2003). To address safety awareness, learn-to-swim programs were introduced for schoolchildren, and training and education programs for all community members. The society also produced a video, titled Watch out for the Kids!, to educate Indigenous parents and carers of the dangers in and around aquatic environments.

Health checks were conducted by the Telethon Institute for Child Health Research to determine whether there were any changes in the burden and severity of ear, eye and skin disease of the children following the introduction of a pool. Early results indicate a marked improvement in their overall health conditions.

No formal evaluation has been carried out in looking at any reduction in drowning and near drowning rates. However, the Telethon Institute of Child Health Research is measuring the community health aspect. Royal Life Saving works closely with the Telethon Institute as their research relies on Royal Life Saving's appropriate management of the aquatic facilities.

The pool managers have been called on to perform first aid outside of the aquatic centre when no nurse or trained person was available in the community. In one community the pool manager attended a compound fracture of a young boy from go-karting, a road crash and a fall from a horse some 50 km away, so the pool managers are invaluable in the community (Lyford 2001):

> Anecdotal reports from health workers in other communities with swimming pools suggest that there had been a reduction in the overall incidence of infections, especially skin, ear and eye infections coinciding with the periods that the swimming pool is open. Physical activity is associated with lower mortality rates and swimming therefore is an appropriate physical activity in hot climates. Furthermore these programs have the potential to decrease boredom in the communities where there is limited social and recreational opportunities. …
>
> Programs are designed to encourage active community participation with the facility providing a strong social focus for the community. Recreational, educational, social and training programs are being implemented and include water polo, Swim and Survive learn to swim, resuscitation and traineeships in Aquatics. …
>
> Each community has adopted a 'no school, no pool' policy or 'school means pool' as one community has more positively coined it, whereby each child is given a daily 'pool pass' for attending school. The children participate in a number of activities at the pool, including swimming lessons, work experience and holiday programs. They have painted brightly coloured murals on the buildings, displaying their creative and artistic talents.

Final results from the Telethon Institute for Child Health Research have yet to be released, however preliminary reports indicate that the children appear healthier since the pools have opened, and the incidence of skin sores and ear infections has decreased. At Burringurrah, ear problems decreased from 90% to 54%, and severe skin sores have decreased from 28% to 3%. Similar results were found at Jigalong.

A number of community members are currently undertaking traineeships providing skills and knowledge to undertake future management and ownership of the facility, through the provision of real career opportunities.

The aquatic facility has become the 'hub' of the community, offering a meeting place within a safe and healthy environment. With effective management and appropriate program implementation, community capacity and community health can be enhanced.

Drowning Prevention Project

The Drowning Prevention Project is a new, Healthway funded project due to commence in February 2003. The purpose of the program is to introduce the Swim and Survive program within the Aboriginal and culturally- and linguistically-diverse groups in Western Australia.

Following quotes are from Lyford:

> Research has also found that the drowning rate amongst Indigenous Aboriginals is three times higher than other Australian children aged 0–14 years, and is ranked the second most common cause of injury death[F].

[F] Australian Institute of Health and Welfare, Child Health Report, 1998.

In remote communities, deaths have been reported to occur in aquatic surroundings including rivers, waterholes and dams, as children will find a way to play in water.

The project will involve conducting discussions with representatives from each target group, developing culturally-appropriate resources and implementing workforce development strategies for staff within 30 specific aquatic centres throughout the state.

Interview

A phone interview was conducted with Marilyn Lyford, Health Promotion Coordinator. Ms Lyford provided an e-mail response to my enquiry and provided additional reference material. In this interview she refers to three different water safety projects in which she has been involved.

CASE STUDY 10 — Safe Dreaming Trails Links Schools

Name of project
Safe Dreaming Trails Links Schools

Brief description of project/program
Safe Dreaming Trails Links Schools is an injury prevention project that uses the school as the setting and the students as agents for change in a cross-cultural, collaborative approach to address community safety standards. Students developed skills in identifying and reporting safety hazards in their school and local community, with opportunities to learn about Indigenous safe community practices through dreaming stories.

Name of organisation conducting the project
Noarlunga Health Services

Description of organisation
Aboriginal health service, Morphett Vale Primary School.

Type of intervention
Injury surveillance, injury surveillance school education awareness campaign, cultural program

Injury problem being addressed
Multiple external causes

Dates of project
2002

Phase
Project completed

Scope
Local

Geographic location
South Australia

Target population
Children

Partnerships
Noarlunga Health Services

Morphett Vale East School

Local service providers

Community members

Other sources of information available about the project
CD-ROM

Background

In 1993, injury prevention was one of the national and state priorities for health. Community members from Noarlunga Healthy Cities expressed concerns about safety in their community. They were successful in their application for funding for the Safe Dreaming Trail to School Project. A Noarlunga Towards a Safe Community forum was formed using the core components of the World Health Organization Safe Communities Network.

Key aspects of the project were:

- providing information;
- developing an effective process for identifying and fixing community safety hazards;
- introducing a cross-cultural focus; and
- working towards reconciliation.

Collaborative links were fostered between health, education, local service providers and the community. The community was invited to participate in the project through the school newsletter. A school committee, made up of school members and parents, organised classroom sessions, and an interactive session focused on community hazards involving workers responsible for community safety issues.

The cultural component of the project was led by a Kaurna elder who introduced the children to Indigenous safe community practices through a dreaming story, Tjilbruke, and a visit to Warriparinga, an important traditional Aboriginal meeting place with significant spiritual value for Kaurna people. The students crossed over the reconciliation stepping stones to enter Warriparinga.

The project also incorporated a Spot the Hazard Walk where child street detectives set out on a trail of exploration and learning. The spotters found a hazardous, cracked pavement, and wrote letters to the council requesting rectification of hazards.

The whole project has been documented on a creative CD-ROM, which highlights the launch of the children's Aboriginal artwork and cultural activities. The Spot the Hazard Walk became the 'safe dreaming trail to school' captured by a stunning piece of Aboriginal artwork

The project is presented as a model for health and education to work together and an innovative approach for teachers to work towards reconciliation.

CASE STUDY 11 — Family Violence Advocacy Project

Name of project
Family Violence Advocacy Project

Brief description of project/program
The Family Violence Advocacy Project developed a model of best practice to address family violence in the Cape York communities. Through this project, a regional group of service providers was formed. A number of information workshops have been run on communities for community women, followed by meetings between community-based services and community women which were facilitated by the project team. Information from the community workshops and meetings was brought back through the regional group Indigenous Family Violence Action Group (IFVAG) who can then work collaboratively towards improved services. This model could be adapted for use by other Indigenous communities throughout Australia. This project has developed resources for communities about issues pertaining to the forms of abuse occurring in the region.

Name of organisation conducting the project
Apunipima Cape York Health Council

Description of organisation
Apunipima Cape York Health Council is the lead agency representing the health needs of Cape York communities. The organisation describes itself as a multidisciplinary health resource whose role it is to identify deficiencies in services and activities influencing health, and to push for solutions. Apunipima adopts a systems advocacy approach where government and non-government service providers are lobbied to improve services and resources to Aboriginal communities in Cape York. The core business of the organisation is to coordinate health activities, facilitate a change in service delivery, and develop innovative solutions in partnerships with communities to improve access to services for Aboriginal people. The River of Life Health Strategy is the framework for Apunipima. It tries to address the social determinants of health as well as clinical health.

Type of intervention
Family violence intervention, workshops, partnerships

Injury problem being addressed
Family violence

Dates of project
The project was launched in July 1999. It was funded for 2.5 years by the National Indigenous Family Violence Grants Program through ATSIC until July 2000, then funded by ATSIC's Family Violence Legal Prevention Program from July 2000 to June 2003.

Phase
The pilot project was completed in June 2001. No long-term funding could be accessed to implement the full model.

Scope
Regional project

Geographic location
Cape York communities, Queensland

Target population
Project intended to cover 16 Cape York communities. It eventually covered around 8 communities.

Funding body
The project was funded by the Commonwealth Government under Partnerships Against Domestic Violence (PADV) as a one-off pilot to develop a model. The grant was administered by ATSIC.

Other sources of information available about the project
<http://www.apunipima.org.au/familyviolence/familyviolenceinfo2.html>

<http://www.premiers.qld.gov.au/about/community/studies.htm>

Evaluation Outcomes: Indigenous Family Violence Action Group, Unpublished Report October 2002.

Building Bridges in Wujal Wujal: Protocols for a Coordinated Approach to Family Violence. Unpublished Report 2001.

Apunipima Cape York Health Council 2000 Annual Report.

Apunipima Cape York Health Council 2001 Annual Report.

Final Report — Family Violence Advocacy Project

Future directions
The project developed an innovative model for dealing with family violence in remote communities; however, no further long-term funding to implement this model could be accessed.

Background
Apunipima Cape York Health Council was established in 1994, following a 4-day health conference with representatives from 15 communities of Cape York and associated homelands. Apunipima was set up as the peak health organisation for the Cape York Land Council and ATSIC Regional Council. It was the first community-controlled health organisation covering Cape York and was a new role model for Aboriginal health services.

Interview
A site visit was undertaken to Cairns. Ms Daphne Naden, project coordinator, was interviewed for this report.

The Family Violence Advocacy Project involved working with women. It was funded by the Commonwealth Government under Partnerships Against Domestic Violence (PADV). It arose from senior women in Cape York speaking out about the high incidence of family violence in their communities. The Women's Health Coordinator had been consulting with these women and working with regional service providers to bring about more coordinated services. Injury from domestic violence had also been identified through the Five Cape York Communities Study (Gladman et al. 1997).

The project involved the development of a model for dealing with family violence, which was trialled and tested as the project proceeded. A strategic plan was developed. This involved:

- using the media to publicise the need for improved services and promote changes;
- integrating family violence educational and prevention programs with the values of the communities;
- developing and distributing information packages;
- strengthening systems, policy implementation and the work practice of government and non-government agencies dealing with family violence, to improve their response to women and children in that situation;
- ensuring that community women were represented in the development of policies and strategies about family violence interventions; and
- being committed to the safety of workers involved in the project.

Model developed

A three-pronged model was developed and piloted fully in the Cooktown cluster. It incorporated:

- Healing our Families family violence workshop;
- Building Bridges workshop; and
- Indigenous Family Violence Action Group meetings.

The Healing our Families family violence workshop was a workshop for women, which used a community development framework. It gave the women information about the different forms of violence, the cycle of violence and the services available. It also aimed to raise self-esteem and provide opportunities.

Building Bridges was a scenario-based workshop that involved a meeting of the local community and local services, including the health clinic, school, police, shelter, and women's and men's groups. Scenarios on domestic violence, sexual assault and child abuse were discussed to find out current service responses. Community members could state their need to service providers, and valuable information was exchanged. Local protocols were set up to deal with how the community groups and services would work together when family violence occurred.

The third part of the project was the setting up of the monthly meeting of service providers, a regional group of up to 20 regional service providers, including government and non-government agencies, such as: Queensland Health, Department of Families, Department of Aboriginal and Islander Policy, Queensland Police, Regional Domestic Violence Service, Queensland Ambulance Service. The group called itself the Indigenous Family Violence Action Group (IFVAG). Issues that had come up during the community group were brought to this regional group. Working groups were set up to address specific issues. Through IFVAG, this was brought to the attention of the Minister for Justice who responded by putting a pilot program on 3 communities to fast-track court hearings.

Indicators of success

One indicator of success was that family violence, sexual assault and child sexual abuse is being talked about openly, largely due to this program. The program used national media, to highlight the problems of the huge incidence of child sexual assault with family members as perpetrators, to bring a difficult subject out in the open.

Other factors identified as contributing to the success of the project were:

1. The acceptability of the organisation leading the project (Apunipima has a lobby role. In the community and people know who they are);
2. Leadership (provided by the Indigenous project coordinator):

> Any project is as good as its leader.

3. Community protocols respected;
4. The neutrality of facilitators (confidentiality respected) facilitated by the neutrality of the project team:

> Apart from Indigenous project coordinator, it was important to have non-Indigenous project officer. Good for personal counselling. Women were able to confide in a person with no family connections in the region;

5. Well-organised and facilitated project (good momentum); and
6. Commitment to change — for example, from service organisations involved in the regional group.

Difficulties encountered

The third prong of the project (IFVAG) was intended to ensure its sustainability. However, getting services committed to change has been a difficulty. For instance, managers from the regional group were asked to delegate someone in their office to be the advocate in their services for domestic violence. This has not always happened because of a lack of commitment from senior people in organisations, and change in personnel in departments.

Major difficulties encountered in working in Cape York are the costs involved in working in large remote areas.

Ongoing funding

There was no ongoing funding for the project. Ongoing means long-term planning and funding:

> Funding for the first project was received for the pilot project to develop a model, but couldn't get ongoing funding to implement the model.

Apunipima identified other issues and applied for funding for that. The Family Violence Advocacy project coordinator stayed on. The Stepping Up Project was funded by PADV (second round). This project identified 'natural helpers' in the communities: community people who do the preventative work, usually women.

Consultants (experts in family violence and social workers) were obtained and 5 communities were identified. The aim was for the consultants to spend 2 weeks in the community educating these people on family violence. They ended up providing the education to all in the community who wanted it.

Some follow-up is now needed for this project, to go back to identify those 'natural helpers 'and also to let the community know those people exist. FaCS funding has been received to give those people work in mothers and babies centres. Overall, the funding for these projects has been insufficient.

With decent funding, they would be able to train people to deliver family violence workshops to pull together the organisations.

A men's group is also being set up:

> (It is) important to see family violence *not* as men's business or women's business.

Other Apunipima projects

A number of other projects are related to the issue of family violence. The Alcohol Management Plan, funded by OATASIH (PHICAC), involves canteen limitations but addresses the problem of generational learnt behaviour and particularly the exposure of kids to violence. While a number of problems could be addressed in just looking at alcohol, Ms Naden pointed out that the problem goes beyond just dealing with alcohol:

> What about kinds that don't drink / families can't do anything. Can't move away. What about men and women who don't drink.

Ms Naden pointed out the problems that occur when specific purpose groups are set up in the community:

> Can't get a community meeting. People are in different interest groups. (There is competition and different layers of coordination.

Ms Naden thought a regional approach, as recommended in Fitzgerald (2001), with the setting up of action plans, was a better approach:

> … then governments could fund the plans.

There is a problem with the current way the role of health workers is defined:

> (Aboriginal health workers are) no longer in the community — (they are) stuck in clinics.

Outcomes

The three-pronged model developed by the Family Violence Advocacy Project gives information about a tried method of improving services for Indigenous women and children who experience family violence. In addition, a number of resources were developed during the life of the project. These included: project briefs; brochures; posters, stickers and T-shirts; information books for community workers; protocols developed as part of the Building Bridges phase of the project; and detailed write-ups of workshops conducted, including minutes of IFVAG meetings and a memorandum of understanding for IFVAG accompanied by an action plan.

Evaluation

An in-house evaluation has occurred, and a report Evaluation Outcomes: Indigenous Family Violence Action Group was produced in October 2002. This document includes a paper to trigger discussion about evaluating IFVAG and participants' responses. No formal analysis has taken place at this time.

Transferability

The program developers view this as a model that could be adapted throughout Australia.

CASE STUDY 12 — CommunityLIFE Project (Indigenous component)

Name of project
CommunityLIFE Project (Indigenous component)

Brief description of project/program
The CommunityLIFE project is based around building community capacity for suicide prevention. It is based on the LIFE framework, the national framework for suicide prevention activities in Australia. The project has a mainstream and an Indigenous component. The Indigenous component parallels the mainstream component but timelines vary to cater for the diversity of the Indigenous population. The project involves direct practical assistance provided to enhance community participation, and skills in planning, implementing and evaluating safe, effective and sustainable life promotion programs for Indigenous communities.

Name of organisation conducting the project
The Centre for Developmental Health (CDH), Curtin University of Technology has overall project management for the national CommunityLIFE project

Description of organisation
University/partnerships

Type of intervention
Information and advice on setting up suicide prevention programs

Injury problem being addressed
Suicide prevention

Dates of project
Funding for the project commenced in the 2002–2003 financial year. The mainstream project commenced fully in September 2002. An Indigenous coordinator has recently been appointed and will begin work on the Indigenous component early in 2003.

Phase
The Indigenous component of the project to begin early 2003.

Scope
National project

Geographic location
Australia-wide

Target population
Indigenous Australians

Funding body
Commonwealth Department of Health and Ageing (National Suicide Prevention Strategy and Office of Aboriginal and Torres Strait Islander Health).

Partnerships

A consortium manages the project:

Centre for Developmental Health (CDH) in Perth

Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) in Adelaide

Suicide Prevention Australia (SPA) in Sydney

National Aboriginal Community Controlled Health Organisation (NACCHO) is also joining the project, with a lead role in overseeing the implementation of the Indigenous component.

Other sources of information available about the project

For a copy of the brochure or for further information e-mail <CommunityLIFE@ichr.uwa.edu.au> or contact Debra Clements, National Coordinator, phone 08 9489 7718.

CommLIFE Paper for Auseinetter Oct 2002 (1)

Progress Report National Suicide Prevention Projects, March 2002, Mental Health and Special Programs Branch, Commonwealth Department of Health and Ageing Care.

LIFE Living Is For Everyone. *A Framework for prevention of suicide and self-harm in Australia.* 2000. Commonwealth Department of Health and Aged Care: Canberra.

Website under development

Future directions

The timeline for the Indigenous component of the project at this stage is 12 months. The group is waiting for the Commonwealth for a second year of funding. It is hoped that the project will continue to be funded, and coordinators are interested in sustainability of the project. They acknowledged that there may be other sources of funding.

Background

The Commonwealth Department of Health and Ageing in June 2002 funded the CommunityLIFE project. It was introduced to operationalise the Life Framework document (Commonwealth Dept Health and Ageing).[G] It addresses the issue of how to deal with suicide prevention at a community level. The mainstream component of the project is responsible for setting up a website, and later an advisory service about setting up suicide prevention programs. The project is about linking people with appropriate information. Rather than offering a direct service, it aims to help communities come up with programs, provide information on best practice guidelines, and offer an advisory service and information through a website.

Funding for the project commenced in the 2002–2003 financial year. During this first year, the project will focus on establishment, by employing relevant staff, on knowledge development and on the establishment of networks and links with the appropriate Indigenous and non-Indigenous stakeholders. An initial brochure has been developed to raise awareness of the project.

[G] LIFE Living Is For Everyone. A Framework for prevention of suicide and self-harm in Australia. 2000. Commonwealth Department of Health and Aged Care: Canberra. A comprehensive framework for suicide prevention activities in Australia is provided in the *LIFE Framework* document.

The broad objectives of the project are to:

- help meet the need in the community for suicide prevention programs;
- build partnerships with key groups to encourage good practice;
- enhance community participation and capacity to plan, implement and evaluate safe, effective and sustainable suicide prevention programs; and
- support knowledge development to inform the Commonwealth and the nation about effective community strategies and programs for suicide prevention.

The Indigenous-specific component seeks to support the implementation in Indigenous communities of life promotion (suicide prevention) activities that are complementary with the mainstream elements of CommunityLIFE and linked to other major Commonwealth-funded initiatives for Indigenous Australians. One of the objectives of the Indigenous component of the project is to make information about life promotion available and accessible in a culturally-appropriate manner.

Community-driven approaches to suicide prevention are particularly important for Indigenous Australians, who take a holistic view of health and understand mental health and suicide prevention issues within the concept of emotional and social wellbeing. CommunityLIFE will aim to make information about life promotion available and accessible to communities, and develop mechanisms for providing support and practical assistance to Aboriginal and Torres Strait Islander communities.

The CommunityLIFE Project will begin with the setting up of a website. The development of the website will involve consultations with community groups to identify the most suitable content and format. In addition, the project will seek information from community groups about what kinds of suicide prevention activities they have undertaken, and recommend local resources and/or feedback on what support and resources would be useful when planning and implementing future suicide prevention activities. In the second stage of development of the website, resource information that has been collected will be made available on the website and links provided to other web-based databases as appropriate. The third stage will include access to resources developed by CommunityLIFE.

The project will undertake a review of the literature on community-based suicide prevention programs and community development approaches relevant to suicide prevention. Good practice suicide prevention resources will then be drafted based on the outcome of the review, and these draft resources will then be trialled. Indigenous elements will be woven thorough all materials developed in the mainstream component of CommunityLIFE.

In 2003–04, CommunityLIFE will complete a pilot and establish a national program development advisory service for responding to requests for information, and support for community-based suicide prevention interventions. The advisory service will provide a central point of contact for all community members and a number of levels of assistance, including assessing and responding to requests for information and/or assistance on community needs analysis, program development, evaluation, and funding sources from individuals and/or organisations. As well as having access to the project database (or resources and networks), the advisory service will be supported by the combined expertise of the consortium members.

Interview

Adele Cox, Indigenous Project Support Officer, <adelec@ichr,uwa.edu.au>.

Jenny Cugley, Executive Officer from the Ministerial Council for Suicide Prevention.

Debra Clements, Coordinator for Community Life.

Liz Bok, Auseinet.

Phone interviews were undertaken with Adele Cox, Jenny Cugley, Debra Clements, and Liz Bok.

The Indigenous component of the project is only just getting under way, with a National Aboriginal and Torres Strait Islander Coordinator recently appointed. Prior to this, Mr Ted Wilkes was the interim National Aboriginal and Torres Strait Islander Coordinator in the setting-up phase of the project.

The first task of the National Aboriginal and Torres Strait Islander Coordinator will be to work out the project plan for the Indigenous component of CommunityLIFE. There are plans to set up an Indigenous project officer in each State and Territory to help communities and organisations to set up programs and offer practical support. The National Aboriginal and Torres Strait Islander Coordinator will work with local and State/Territory agencies to determine the most appropriate agency to house the coordinator.

The Indigenous component of the project addresses the high suicide rate within Aboriginal communities. Although not implemented at this stage, interviewees commented on the importance of working at the community level to empower Aboriginal communities to come up with their own solutions. A broad community development perspective is taken. It was recognised that communities also need guidance, and the information provided by CommunityLIFE is intended to guide their process.

The detail of the Indigenous component will depend on the direction of the National Aboriginal and Torres Strait Islander Coordinator. There has been some preliminary discussion about the need for grants for practical assistance — for example, information on where to go to and how to get assistance. The project does not have the resources to provide training but will be able to link people to training. There is a need to find out what is already available within the States and Territories.

The project hopes to link communities and agencies to networks in States and Territories. It is acknowledged that it is important to linking people with existing available resources.

CASE STUDY 13 — Men and Family Relationship Initiative

Name of project
Men and Family Relationship Initiative.

Brief description of project/program
The project addresses family violence in a holistic way. It involves offering a drop-in facility, individual counselling, group work training for court mandated and voluntary client groups, community education, liaison with local service providers and advocacy. It also provided an outreach service to Indigenous men in the Broome shire communities and supported the establishment of similar services in the Kimberley.

Name of organisation conducting the project
Men's Outreach Service, Broome

Description of organisation
The Men's Outreach Service is a town-based service for men located centrally in Broome.

Type of intervention
Men's Outreach Service

Injury problem being addressed
Domestic/family violence, general violence, self-harm — drugs, alcohol, self-harm/mutilation, suicide

Dates of project
July 2002 (previously under the women's refuge from 1999)

Phase
Ongoing

Scope
Regional project

Geographic location
Kimberley region, WA

Target population
Indigenous males

Funding body
Commonwealth Department of Family and Community Services, PADV (men's pilot program); other funding received from WA Ministry of Justice, Safer WA program.

Partnerships
The service has linkages with the women's refuge, CDEP workers, Broome police, Centrelink, NW Mental Health and Drug and Alcohol Service, drug rehabilitation service and other local agencies.

Future directions
The future of this project will depend on the availability of further funding.

Background

The Men's Outreach Service began as a project of the Marnja Jarndu Women's Refuge Inc, which has a focus on family violence and the needs of each part of the family. It was initiated to address family violence in a more holistic way. Many women do not apply for restraining orders. They want the family to stay together; they just want the violence to stop. Also, restraining orders are not practical for many families, especially in remote communities. The project provided a town-based service located centrally in Broome offering a drop- in facility, individual counselling, group work training for court mandated and voluntary client groups, community education, and liaison with local service providers and advocacy. It also provided an outreach service to Indigenous men in the Broome shire communities and supported the establishment of similar services in the Kimberley.

Interview

A telephone interview was carried out with Phil Horner, then coordinator of the men's outreach program. Mr Horner started as the administration worker, part time for 6 months, then for the last 6 months as coordinator. He also does some counselling, public relations, recruitment, staff development, outreach, and group work. Bruce Cooper is the current administrator of the Men's Outreach Service.

The project was introduced due to the high rates of domestic/family violence. The women were saying they wanted the men to change and to see improve family relationships improved. The women's refuge saw there was money available and initiated the project.

The Commonwealth Department of Family and Community Services Partnerships Against Domestic Violence funded the project under the men's pilot program. Other funding sources were: the WA Ministry of Justice (to run prison and parole groups and visit communities and clients outside Broome shire); and the Safer WA program (to top up the drop in funding).

According to Mr Horner, the sorts of injuries that occur in Indigenous communities include suicide, murder, child abuse, broken bones, cuts, bruising, bashing, and mental health injury. The major factor contributing to these kinds of injuries occurring in the Broome area include substance abuse — mainly alcohol and marijuana — and factional violence/family feuds.

The house in town provided day facilities for men to take care of their basic needs — washing, washing clothes, and having a feed, as well as some recreational activities and the opportunity to talk informally or in a counselling session. It ran anger management and substance abuse groups with men mandated from the justice system, and volunteer groups with men from the Broome prison and drug and alcohol clients. It supported men to access town and city services. Regular visits to the Broome shire communities were undertaken to speak to men and provide support.

Resources required to run the project included: staff; transport; communication resources (phone, fax and e-mail); various written and audiovisual material; consumables (personal hygiene items — soap, razors, toothbrushes); and recreational facilities (TV, video, pool table, cards etc). Safer WA provided the consumables. Office equipment was set up from core funding. The vehicle was on loan from the women's refuge. There were some donations.

On a day-to-day level, the staff worked with a management committee form the Women's Refuge Inc and a men's reference group, which later incorporated. Those involved in the project included: the women's refuge; the men's reference group; and the staff (a White counsellor/coordinator, an Aboriginal men's project officer, a White part-time administration worker and an Aboriginal CDEP worker on top-up who supported the drop-in clients). There was also interaction with: the Broome police; Centrelink; NW Mental Health and Drug and Alcohol Service; Milli, drug rehabilitation service, and other local agencies; and Broome shire men, community men and itinerant clients — predominantly Indigenous clients.

In answer to a question about how well was the nature of the injury problem understood by the intervention/project, Mr Horner stated that the problem was well understood but it was difficult to find appropriate models to use:

> There is a great wealth of health info about the Kimberley.
>
> Other info; Anecdotal — from local people, sharing knowledge and info with co-workers and other local agencies, court experiences, journals/government reports an other literature. Local cultural awareness training.

He would have liked more knowledge about mental health. He has come to realise that there are more and more people affected by mental health issues — adult difficulties/dysfunction can be tied to child abuse:

> There is a lot of good information. You need plenty of solid info to really grasp what's going on.

According to Mr Horner, the project has established a fairly firm foundation. It needs to expand. It needs to be flexible to respond to opportunities that arise.

There have been a few problems with assumptions about the way things are from the funding body, because they are not aware of conditions in the Kimberley:

> Also men don't seek counselling — particularly Indigenous men, maybe only when things are at crisis point. So then it's hard to do anything when women contact us to "fix our perpetrators". It's a slow process with a few wins along the way.
>
> There also is a need for accommodation and meals — we only provide tea and toast (bread donated by local businesses). …
>
> More preventative work would be better.

The project has had an impact:

> The general level of health of drop-in clients has increased. Feedback from other people around town working with the same clients say the fellas look better than they have in the past. It provides a circuit breaker for violence, and a retreat environment for the homeless men.
>
> It takes the steam out of a lot of crisis situations and reduces the risk of violence. The police say "we've calmed things down" — it is said that there is less engagement with the criminal process.
>
> It's improved men's access to local services. With some advocacy men have calmed down. It's helped men deal with local business and service organisations. It makes things possible. It's improved access to and support from a range of agencies.
>
> The Broome mental health service has been able to keep a better track of their clients who may not turn up for their appointments but will be able to ring us and check as their clients usually use the drop-in service.
>
> There is less alcohol related street crime.
>
> At this stage the reduction in injury has been a minor improvement, but it has *definitely made a difference*.

> We're still building confidence. Men are too proud to admit they need help.

Although the service is widely known around town and in the wider area, information about the service has not yet reached all who might have benefited.

Evaluation

There have been two external evaluations of the service. The final reports have not come out yet.

Those who benefited the least from this project were the victims of violence:

> Women ring up and say, " Can you help him".

The broad community response was very positive in terms of moral support and collaboration:

> The service was well recognised. The community is very pleased it's happening because there is less alcohol-related street crime. But it is hard to say if there is less violence. …
>
> The structures put in place were devised by a white bureaucracy — it could have been more culturally sensitive. We could have done more short, sharp educational activities for clients, e.g. coping strategies, knowledge of how system/agencies work, access to services. There is so much misunderstanding and people give up.

Those who benefited the most from the intervention were the town clients, semi-homeless and homeless men in Broome:

> Removed a bit of stress and got them out of a trouble.

In your opinion was it cost effective?

> Very, very cost-effective. It's a very good investment. In this environment, it takes a long time to build relationships.

The project could be replicated across the Kimberley or in any town with a high Indigenous population:

> The project provided a great opportunity for people to increase their understanding and be aware of the consequences of their actions. Learned a lot. It was heartening stuff. Good feedback. Being patient and building trust.

Is there anything you would do to prevent injuries that you think has not been done already?

More money.

Develop more media-based communication that challenges people's behaviour — well-designed TV stuff that challenges attitudes and values in a really powerful way.

Support elders to talk and provide leadership — young people have lost/are losing respect.

CASE STUDY 14 — Community Education Program for Aboriginal and Torres Strait Islander Communities

Name of project
Community Education Program for Aboriginal and Torres Strait Islander Communities.

Brief description of projects/programs
This project was organised in conjunction with Queensland Health. It involves the development of an ongoing and culturally-appropriate training and support program to help Cape York/Torres Strait communities prevent and respond to health care emergencies and injuries. The project set up in-service and community access/health promotion and injury prevention programs through the placement of field officers in the Cape York and Torres Strait regions to develop preventive first aid. The projects have been going since about mid-2002. A field office has been established in the town of Coen, and the Field Officer has been involved in setting up and conducting full first aid courses as well as safety awareness, injury prevention programs and education in the remote and isolated communities of Kowanyama, Pormpuraaw, Lockhart River, Mapoon, Coen and the outstations associated with these communities. There are plans for the project to be expanded to Horn Island (Torres Strait Islands), Kowanyama and Cooktown.

Name of organisation conducting the project
Queensland Ambulance Service (QAS)

Description of organisation
Emergency service

Type of intervention
Field officer model.

Injury problem being addressed
All injuries — prevention and first aid courses

Dates of project
The Coen Field Office was established and the Field Officer appointed in June 2002.

The field office at Horn Island will commence operations on 17 February 2003.

Phase
The project is ongoing.

Scope
Regional project

Geographic location
Cape York Peninsular and Torres Strait, Queensland

Target population
Remote Indigenous communities and outstations, Cape York Peninsula and Torres Strait Islands.

Funding Bodies — Consultation Procedure, Publishing and Printing of Reports
Queensland Health (Better Practice for Improving Indigenous Health Program), Queensland Ambulance Service, RHSET.

Other sources of information available about the project

Community Education Program for Aboriginal and Torres Strait Islander Communities is a project conducted by the Queensland Ambulance service and funded by the Rural Health Support, Education and Training (RHSET) Grants Program of the Commonwealth Department of Human Services and Health in April 1999.

A Pre-Hospital Care Model for Isolated Aboriginal & Torres Strait Islander Communities. (1998). Queensland Ambulance Service; Rural Health Support Education and Training.

Enhancing the Capacity of Cape York Communities to Prevent and Respond to Health Care Emergencies and Injuries. September 2000. Queensland Government Department of Emergency Services: Queensland Ambulance Service.

Enhancing the Capacity of Islander Communities to Prevent and Respond to Health Care Emergencies and Injuries. Report and summary July 2001. Queensland Government Department of Emergency Services: Queensland Ambulance Service.

Reports are also on the QAS website <http://www.ambulance.gov.au>; Go to "What's New — Publications".

Background

In 1994–95, first aid training was provided by QAS to Queensland Fire Service and State Emergency Service volunteers in eight Torres Strait Island communities, through a grant from the Commonwealth Department of Employment, Education and Training (DEET).

In 1995–96, a Queensland Department of Employment, Vocational Education, Training and Industrial Relations (DEVETIR) training grant was obtained to provide first aid to Indigenous communities in the Cape York Peninsula area.

In 1995–96, through a grant provided by the Torres Strait Regional Authority, first aid training was provided to all Torres Strait Island communities.

In 1996–97, the Rural Health Support, Education & Training (RHSET) Program of the Commonwealth Department of Health and Family Services provided a grant through which first aid and basic life support training was given to all Cape York Peninsula Aboriginal communities and eight Torres Strait Island communities. Objectives, outcomes and recommendations of this program are set out in the QAS RHSET Program Report, *Community Education Program for Aboriginal and Torres Strait Islander Communities* (April 1999).

In 1998, *A Pre-Hospital Model for Isolated Aboriginal and Torres Strait Islander Communities* was published. This was a project to research the establishment of a pre-hospital care model for Indigenous communities, and was funded by the Rural Health Support, Education and Training (RHSET) Program of the Commonwealth Department of Health and Family Services, and the Queensland Ambulance Service.

In 1998–99, there was a Queensland government initiative to enhance the ambulance service to Aboriginal and Torres Strait Islander communities, with funding over three years. Recommendations of the RHSET report were used as a basis for directing this funding towards the establishment of the Aboriginal and Torres Strait Islander Coordination Unit (established in Cairns in the 1998–99 financial year) and for the establishment of QAS stations on Mornington Island, Palm Island and Doomadgee, for which funding was approved during the 1999–2000 financial year.

In 2000, *Enhancing the Capacity of Cape York Communities to Prevent and Respond to Health Care Emergencies and Injuries* service plan was published.

In 2001, *Enhancing the Capacity of Islander Communities to Prevent and Respond to Health Care Emergencies and Injuries* service plan was published.

Interviews

Interviews were carried out with: David Eeles, Assistant Commissioner, Queensland Ambulance Service; and Paul Elliot, State Coordinator, ATSI Coordination Unit, Queensland Ambulance Service.

Queensland Ambulance Service has undertaken a number of initiatives, projects and programs to improve safety and injury prevention and first aid programs among Indigenous people. These have been published and are available on their website.

An initiative from one of the recommendations of *Enhancing the Capacity of Cape York Communities to Prevent and Respond to Health Care Emergencies and Injuries* service plan was the establishment of a field office at Coen to service the communities of Coen, Lockhart River, Kowanyama, Pormpuraaw, Aurukun and the outstations associated with these communities. The field office has been established and the field officer was appointed in June 2002. The field officer in the Coen area is currently implementing the recommendations of the report.

The Queensland Ambulance Service has also now secured the capital and recurrent funding for the Kowanyama Field Office. It is envisaged that this office will be established during 2003, and will take over from the Coen Field Office the areas of Kowanyama and Pormpuraaw and the homelands/outstations associated with them.

Funding has been approved for the field officer position at Horn Island. The field officer has been appointed and it is expected that the field office will commence operations in existing QAS accommodation at Horn Island on Monday 17 February 2003.

The recommendations of the *Enhancing the Capacity of Islander Communities to Prevent and Respond to Health Care Emergencies and Injuries* service plan will be implemented once the field office is operational on Horn Island.

David Eeles pointed out that the demand for an ambulance service in Indigenous communities in the north Queensland region is 5 to 10 times the rate of all Australians.

Community consultation

The problem that had to be addressed is 'what's needed' in the Cape York region, which is vast, remote and isolated, and has many smaller communities. Consultation with communities in the Torres Strait was undertaken during October 2000. Community views were sought about how emergency health care and pre-hospital care could be improved and about the training needs of communities. Information about health and injury was also disseminated.

Field officer model

As a result of the consultations with Indigenous councils in Cape York Peninsula and the Torres Strait, and as part of a five-year plan developed, the Queensland Ambulance Service decided on the field officer model. It was a proactive approach to the whole system and addressed prevention, education and access. The field officer provides comprehensive, regular, community-wide training, including first aid, basic life support, pre-hospital care, and injury prevention training, and helps support health promotion and prevention initiatives.

Partnership Approach

The project was a whole-of-government approach, which involved partnering with government and non-government agencies, Indigenous organisations, community councils and Aboriginal corporations. It depended on the willingness of organisations, as neither Queensland Health nor the Queensland Ambulance Service alone can cost effectively address the Cape York communities' pre-hospital and emergency care needs. For example, the Queensland Ambulance Service through the field officer provided in-services and training in first aid, the local health service had a vehicle, and land and sea management were also involved.

Some factors affecting success of project are:

- the willingness of community members to be involved;
- the setting up of a steering group of stakeholders;
- consultation in Cape York Peninsula and the Torres Strait;
- establishment of a field office in Coen; and
- establishment of a QAS Indigenous Coordination Unit in 1998.

CASE STUDY 15 — Indigenous " STRONG" Safer Sport Pilot Program

Name of project
Indigenous "STRONG" Safer Sport Pilot Program.

Brief description of project/program
The Indigenous "STRONG" Safer Sport Pilot Program was a pilot program supported by the Australian Sports Commission (ASC) and coordinated by the NT Branch of Sports Medicine Australia (SMA). It involved a one-day safer sports training workshop in Yirrkala community, east Arnhem Land, presented in December 2002. The workshop addressed topics such as basic anatomy, warming up and cooling down; what to do about injury; treating sprains, pulled muscles and skin; treating head, neck and back injuries; using the first aid kit; taping; medical conditions such as diabetes and asthma; food and water; drugs in sport; and making sport safer.

Name of organisation conducting the project
Batchelor Institute in conjunction with Indigenous Sports Program (Australian Sports Commission) and Sports Medicine Australia (NT).

Description of organisation
Batchelor Institute is an institute of higher education located in Batchelor, NT. Its vision is a unique place of knowledge and skills, where Aboriginal and Torres Strait Islander Australians can undertake journeys of learning for empowerment and advancement while strengthening identity

Type of intervention
One-day workshop

Injury problem being addressed
Sports injury

Dates of project
December 2002

Phase
Project implemented December 2002

Scope
Local project

Geographic location
Northern Territory: pilot study in Yirrkala community, east Arnhem Land

Target population
Remote Indigenous communities

Funding body
Sports Medicine Association

Partnerships
Batchelor Institute

Indigenous Sports Program (Australian Sports Commission)

Sports Medicine Australia (NT).

Other sources of information available about the project

Fiona Cummins, Lecturer, Batchelor Institute, 37 Gregory St, Parap NT 0804;
Phone: 08 8946 3817; Fax: 08 8946 3819

Future directions

The STRONG pilot program has not yet been formally evaluated but was seen as a success. There were some recommendations for improvements to the training manual for future programs. These recommendations are to be modified prior to the next pilot program in the Tiwi Islands.

Background

The Indigenous "STRONG" Safer Sport course was introduced because the Level 1 Sports Trainers course (SMA) was too heavily dependent on literacy skills and also too long to really gain the interest of Indigenous communities. A one-day bridging course was designed to assist in bridging the gap, and also to be able to be delivered by Indigenous Sports Officers in remote communities of the Northern Territory.

The sports injury prevention curriculum was initiated by the Indigenous Sports Program (Australian Sports Commission) and Sports Medicine Australia (NT), and funded by the Australian Sports Commission. The curriculum was written as a cooperative exercise involving all stakeholders and then piloted in Yirrkala in December. The curriculum provides information about bones, muscles, joints, tendons, ligaments, DRABC, body movement, drugs in sport and basic medical problems (diabetes and asthma), but predominantly teaches how to treat sprains, pulled muscles, skin problems, etc. The students practise taping ankles, thumbs and fingers, the most common sport injuries.

Interview

A phone interview was conducted with Ms Fiona Cummins, Lecturer, Batchelor Institute.

Fiona Cummins was the sports educator and a member of the consultative committee, as well as an Executive Board member of the Sports Medicine Association. She assisted with the curriculum writing but predominantly set up the course in Yirrkala with work contacts, who assisted in the presentation and marketing of the course and wrote the evaluation.

The project ran as a pilot program, with twenty-two male and female Indigenous students (aged 14–17 years) participating in the course and four teachers supervising and participating.

The resources needed for this project included: airfares to Yirrkala; funding for the presenter and student workbooks; T-shirts for participants, design and printing costs; and consultancy fees. Course presenters were Tracey Parker, Executive Officer, Sports Medicine Australia (NT); Michelle Harrison, Education Officer, Sports Medicine Australia (NT); Kate Buckeridge (Miles), curriculum writer; Chris Lewis, role model; Gus David, ISP Officer, NT Office of Sport and Recreation; and Fiona Cummins, Batchelor Institute.

Evaluation

At this stage, the participants have not evaluated the project but the presenters, participants and the associated organisations that were involved in the delivery saw the pilot program as successful due to:

- the delivery of the workshop on time and under the agreed budget (partially due to no accommodation requirements);
- educational outcomes highlighted by the increased knowledge and skills demonstrated by the participants;
- the participants enjoyed the course and were engaged by each session;

- the resources developed for the program (both participant's booklets and presenters manual) received positive feedback from all involved;
- the training course ran smoothly, including the transition from each section, and all presenters were well prepared and trained in their required topic; and
- the selected role model (Chris Lewis) was well respected by all participants — and it was noted how vital the impact of an Indigenous role model was to the success of this program.

There were positive outcomes in terms of attendance and verbal feedback.

As the project was piloted in December 2002, it is too early to estimate the impact on the participants, and for their community to know what difference the project has made including whether it has it prevented or reduced injury.

According to the sports educator, this project:

> … provided a great opportunity to see something from just an idea develop through to an actual program run in a remote community.

Resources developed

A presenter's booklet 'Preparing you for the Level 1 Sports Trainer Course' was developed. The booklet covers topics such as: 'Your job as sports trainer', basic anatomy, warming up and cooling down; what to do about injury; treating sprains, pulled muscles and skin; treating head, neck and back injuries; using the first aid kit; taping; medical conditions such as diabetes and asthma; food and water; drugs in sport; and making sport safer. Appendices included: a stretching poster; standards drinks chart and healthy eating pyramid.

CASE STUDY 16 — Port Youth Theatre Workshop Project

Name of project
Port Youth Theatre Workshop Project

Brief description of project/program
The Port Youth Theatre Workshop project involved two pilot projects (Warritti 1 and Warritti 2) in 1997 and 1998 with Indigenous children aged 5–8 and 9–12 years. The project was meant to address the issue of family violence, and provide a safe and creative way to explore emotional issues and ways of dealing with feelings. The first program worked through cartoons and drawings and involved the production of a series of workshop resource booklets. The second program used puppets to enable children to deal with their feelings and experiences before being taught more complex models of handling conflict. The final outcome of the workshops was a resource kit consisting of a video, facilitator's workbook and booklets.

Name of organisation conducting the project
Port Youth Theatre

Description of organisation
Community theatre

Type of intervention
Community cultural development model

Injury problem being addressed
Interpersonal or family violence

Dates of project
Workshops, 1997; resource published 1998

Phase
Project completed: the theatre is now involved in other community projects.

Scope
Local project

Geographic location
Adelaide

Target population
Indigenous Children in the Port Adelaide area

Funding body
Commonwealth Government PADV

Partnerships
The workshops were a response to an Indigenous community request. The theatre worked in collaboration with the local community.

Other sources of information available about the project

Port Youth Theatre Workshop, ph: 08 8341 1150

Commercial Road, Port Adelaide SA 5015

<pytw@chariot.net.au>

Yitpi: fun with feelings [English] [Aboriginal language(s)] [Ngarrindjeri] [Kaurna] [Pitjantjatjara], Port Youth Theatre Workshop, Port Adelaide, SA: Port Youth Theatre Workshop, 1998. Available online at: <http://www.padv.dpmc.gov.au/oswpdf/dv_strategies.pdf>.

Future directions

Resource is currently available. The workshops are not ongoing at the present time.

Background

The Port Youth Theatre Workshop project was funded by Partnerships against Domestic Violence (PADV). It was one of 12 initiatives, Indigenous Partnerships Projects, written up in 'Key findings' June 2000. Port Youth Theatre was also featured as a case study in the publication: Strategic Partners 2000 'Domestic Violence Prevention: Strategies and Resources for Working with Young People'.

Port Youth Theatre was approached by an Aboriginal Advisory Group with a request to run groups for small children aged 5–12 years. The request was for an innovative way to assist these children deal with violence, the assumption being that at some time all had witnessed violence either in their home, school or community.

The initial approach was a pilot project, which employed an Aboriginal graphic artist and a non-Aboriginal cartoonist. A key factor at this point was the establishment of a support group of experienced Aboriginal workers. These workers, with a focus on spiritual and emotional wellbeing, acted as the mentors and support persons for the young people during the six workshops that were conducted. Their prime role was to take care of the children during the workshops and assist the specialist tutors employed.

In the workshops, the children were encouraged to draw their own emotions when presented with violent situations. For example, one activity was to draw a happy face, a sad face, etc. They were encouraged to be expressive in their artwork and to use a variety of methods, and to draw on various 'surfaces'. To support their self expression, the Aboriginal mentors would tell stories: sometimes their own, sometimes stories from Aboriginal spiritual sources. The key focus was to provide a totally safe place for the children where they would enjoy drawing and gain support. So that the children had something specific to take home, they were given a 'workshop sheet' after each workshop. The worksheet summarised what had happened and could be used as a discussion starter with their parents. (Each of the parents had been contacted separately about their child's involvement).

This first workshop was divided into four groups: 5- to 8-year-olds and 9- to 12-year-olds, with the boys and girls separate to allow for even greater freedom of expression. Each child was given a card with the names and contact details of workers in the workshop, for contact if needed between workshops. Key factors in the success of the workshops were the provision of transport for the children and the provision of food, which contributed to the environment of safety and support.

In terms of the workers, a critical feature was the creation of a debriefing session to discuss the workshop and the expression of emotion that transpired. This was vital, as the work by the children was often emotionally charged and would trigger responses in the workers.

Following the success of the first workshops, a second series was conducted, using puppets to assist the children draw out their emotions: 'What does a happy puppet look like?' 'What about a sad puppet?' The children were encouraged to draw on the puppets and create the make-up. They then put on puppet shows, giving a further opportunity to express their feelings about violence. This expression was in the third person, which made it safe for the participants.

The third step was when Port Youth Theatre arranged with another Aboriginal group, who had received funding from Partnerships Against Domestic Violence, to use the theatre for the production of a resource based on the previous workshops. This time they were able to employ someone to video the workshops and the puppet shows and, more importantly, they were able to employ someone to 'interview' the children and begin to develop resource books on each emotion. Various people then developed the 'Yitpi: Fun with Feelings' resource kit. The cartoonist and the graphic artist worked together to produce the kit, which is available as a significant resource for workers in this field.

Interview

Phone interviews were conducted with Georgie Davill, theatre administrator, and briefly with Josie Agius, Aboriginal Community Networker, who works part-time at the theatre helping with the children and performances and providing a connection to the community.

The project was originally funded by PADV, however Ms Davill explained that Port Youth Theatre Workshop works on a relevance classification. They are tapped into 'arts projects', 'general health', 'health promotion', 'law', 'anti-crime' 'big project', and are currently working on a language revival project.

Since the workshops, which produced Yitpi: fun with feelings, there have been new staff and there is no continuation of the project at present. It may go back into a project in the future, however. Although that specific project will have no flow-through, the resource that was produced would continue to raise awareness around bullying, violence and emotional support. The resource is now something that the organisation uses.

According to Ms Davill, the trouble with projects like this is that the funding is not for long term. People working in a particular area of development find this problematic. An evaluation was carried out at the time of the project, but there has been no long-term evaluation to assess the project's long-term impact. It was noted that organisations are never resourced to actually assess that.

What makes the project successful? Josie Agius said that the success of the project, when it occurred, was due to:

> … the individual people that worked at the theatre, including younger workers who were skilled and artistic, knowing the kids (5- to 16-year-olds), the kids being able to feel safe, the community, knowing that Josie and others are there.

What difference has the project made?

> Children that come here have been through abuse — sometimes we can see that in the action of children. This gives children choices — some have workshops every night of the week.

CASE STUDY 17 — Injury Prevention in Indigenous Communities Project

Name of project
Injury Prevention in Indigenous Communities Project.

Brief description of project/program
This project addresses the high priority area of alcohol-related injury in Cape York communities. The project is part of a set of programs, managed by Injury Prevention and Control (Australia) Ltd, that aim to establish and implement best practice approaches to the prevention and management of injury in a range of priority settings. Its focus covers injury prevention across the life span, including: children, young adults, working-aged persons, older persons and Indigenous Australians. The overall aim of the Injury Prevention in Indigenous Communities Project is to establish, implement and evaluate more effective ways to prevent injury in Indigenous communities in north Queensland. A fundamental aspect of the project is to set up and maintain active working partnerships among communities and stakeholder organisations.

Name of organisation conducting the project
North Queensland Indigenous Injury Prevention Partnership (NQIIPP)

Description of organisation
Partnership

Type of intervention
Public health model of injury prevention; basic and applied research

Injury problem being addressed
Alcohol-related injury

Dates of project
Funding was received early in 2002 and is expected for a five-year period until 2007.

Phase
First 12 months of project

Scope
Regional project

Geographic location
Far North Queensland

Target population
Indigenous population across the life span — pregnancy to old age

Funding body
National Health and Medical Research Council (NHMRC)

Partnerships

A formal steering committee has been formed with representation from the following organisations:

- University of Queensland;
- Tropical Public Health Unit;
- Apunipima Cape York Health Council;
- Cape York Health Service District;
- Royal Flying Doctor Service;
- Aboriginal Coordinating Council;
- Queensland Ambulance Service;
- Queensland Police; and
- Department of Aboriginal and Torres Strait Islander Policy Development.

Other sources of information available about the project

NQIIPP, the University of Queensland and Tropical Public Health Unit, 19 Aplin Street, PO Box 1103 Cairns, Qld 4870.

NQIIP information sheet <Melissa_haswell@health.qld.gov.au>

Future directions

The project is expected to continue until 2007.

Background

The North Queensland Indigenous Injury Prevention Partnerships (NQIIPP) was formed in 1999 by a group of researchers and health professionals in north Queensland. The group is led by Professor Ernest Hunter from the University of Queensland and Professor Robyn McDermott from the Queensland Health, Tropical Public Health Unit. A steering committee with wide organisational representation was established (see 'Partnerships', above). NQIIPP began receiving funding for the Injury Prevention in Indigenous Communities Project from Injury Prevention and Control (Australia) Ltd from mid-2002. The project is based in the Cairns office of the University of Queensland, with Dr Melissa Haswell-Elkins and Ruth Fagan (University of Queensland) working part time on the project from mid-2002.

The very high rates of injury and deaths among Indigenous communities in the Cape York communities had already been identified by a number of major reports as being much higher than other parts of Queensland. (Gladman, D. et al. 1997; Fitzgerald T. 2001; Aboriginal and Torres Strait Islander Women's Task Force on Violence, 2000). Alcohol was identified as a major contributing factor (Gladman, D. et al. 1997). The remoteness of the communities makes the provision of any health services both difficult and costly. There is a need for sustainable projects to assist communities to prevent injuries, and to respond quickly and effectively when an injury occurs.

The specific aims of the NQIIPP project are:

- to develop, through systematic reviews and basic research activity, the evidence base to inform effective injury intervention initiatives in Indigenous communities, with a specific focus on alcohol-associated intentional injury;
- to develop a set of linked injury databases to enable monitoring of prevention programs in Indigenous communities and adequate evaluation in terms of population health outcomes;

- to demonstrate the effectiveness (minimising the burden of injury) of population-level intervention programs in Indigenous persons; and
- to document a transferable process of establishing and maintaining active partnerships as a model for national public health injury prevention and for other initiatives that focus on complex health problems.

The objectives of the first year of the project were:

- to focus resources and expertise, across an extensive range of organisations and services in Cape York, on the problem of increasingly high rates of injury;
- to develop a database of relevant injury-related information across the spectrum of prevention to rehabilitation, including undertaking a literature review of strategies and models for injury prevention, early intervention and treatment in Australia and overseas; to identify priority issues for NQIIPP; and to identify and document current and proposed programs related to injury prevention in Cape York;
- to enhance information systems to ensure that comprehensive information is available;
- to use a continuum of care pathways to harm-and-recovery model, and ensure injury-related information is used to inform all injury-related activities; and
- to facilitate broad strategic planning and provide a means for an evaluation feedback loop at agency and strategic levels.

The project uses qualitative and quantitative methodologies. A crucial part of the project is the establishment of a communication, information-sharing and collaborative network among individuals and organisations who are active in the prevention and management of alcohol-related injury among Indigenous people in Cape York. Information is currently being documented on: what has been done in the past, what has worked successfully and what hasn't; what types of data are currently available to quantify and help understand the context of injury; and what organisations are involved in injury prevention and management.

NQIIPP's approach to injury prevention and management is adapted from the mental health continuum, which describes a continuum of levels of intervention from universal prevention to rehabilitation and aftercare. NQIIPP has adapted this model by focusing on five key alcohol-associated injuries across the developmental spectrum. The priority types of alcohol-related injury are:

- alcohol in pregnancy (pregnancy);
- physical child abuse (infancy);
- sexual child abuse (childhood);
- intentional self harm (teens/young adults); and
- interpersonal violence (adulthood).

Interview

A site visit was undertaken to the Tropical Public Health Unit, Cairns. Professor Ernest Hunter was interviewed and the following additional issues raised.

Injury rates

It is difficult to generalise about injury rates. A small percentage of the population has a higher percentage of injury burden. It was pointed out, for example, that Cape York and Torres Strait have a high burden of injury.

Vulnerable groups

Professor Hunter identified the elderly, children and people with mental illness as vulnerable groups for injury:

- aged care often gets missed in planning but there is an elevated risk in keeping old people in the community — dementia can lead to high risk of injury and can be a hidden problem;
- a second vulnerable age group is childhood — this includes children with alcohol-related birth defects, which can be considered an injury; alcohol-related birth defects often do not get picked up in children because they can seen as attention deficit disorder (ADD) but they do not respond to conventional treatment — these children are also at risk for injury and harm to others; and
- we need a model of care for people with serious mental health problems — this group is also at high risk of injury.

The NQIPP injury project is attempting to address the needs of these vulnerable groups. They will be facilitating Apunipima Health Council to look at a spectrum of treatment through to prevention, looking at key injuries in each age group

Innovative care models.

Professor Hunter stressed the need for innovative care models. An example was provided of a proposed Health Promotion Queensland Project involving information technology through touch-screen computers (kiosks) in communities. This can be a resource for aged care, diabetes and alcohol issues. This facility will also provide feedback and facilitate data collection.

CASE STUDY 18 — Education Centre Against Violence (ECAV)

Name of project
Education Centre Against Violence (ECAV)

Brief description of project/program
ECAV has developed a VETAB accredited Certificate IV course for a new group of Aboriginal Health Workers, called Aboriginal Family Health Workers, to address issues relating to family/domestic violence and sexual assault and child abuse in Indigenous communities. The course comprises six modules and the equivalent of 190 hours face-to-face classroom contact. Included within the course is 40 hours of on-the-job, fieldwork experience. Recognition of prior learning and work experience will be taken into account and credited for particular subjects. Course subjects are currently delivered in one-week blocks.

Name of organisation conducting the project
Education Centre Against Violence (ECAV)

Description of organisation
The Education Centre Against Violence (NSW Health) develops and delivers a comprehensive range of domestic violence training programs.

Type of intervention
Education and training — domestic violence prevention

Injury problem being addressed
Domestic violence, sexual abuse, child sexual abuse

Dates of project
The program was set up in 2000.

Phase
The program is ongoing, depending on funding.

Scope
State-wide program

Geographic location
New South Wales

Target population
Aboriginal and non-Aboriginal workers in health, welfare, accommodation and legal services who come into contact with people affected by family/domestic violence, sexual assault and child abuse.

Funding body
NSW Health

Partnerships
Aboriginal Health Unit (NSW Health)

Other sources of information available about the project
<http://www.padv.dpmc.gov.au/>

Course Information

Mareese Terare, Education Centre Against Violence, Parramatta NSW
ph (02) 9840 3737 fax:(02) 9840 3754 e-mail <Mareese_Terare@wsahs.nsw.gov.au>

Future directions
The program is ongoing.

Background
The Certificate IV Family/Domestic Violence & Sexual Assault (Aboriginal Family Health) course was developed in collaboration with Aboriginal Health Branch NSW Health, and takes into consideration the underlying principles of the 1995 Aboriginal Family Health Strategy. It provides the opportunity for Aboriginal workers to explore together their understandings of, and responses to, family/domestic violence, sexual assault and child protection. It raises awareness of the social/cultural context in which family/domestic violence is located, exposes the inadequacies of individualistic explanations of family/domestic violence, explores familiar issues surrounding family/domestic violence and the practical implications of these. It promotes intervention that prioritises the safety of victims, and locates responsibility for violence entirely with the perpetrator. The course uses some ideas from narrative therapy and is experiential.

The course has industry recognition and is specifically designed for workers in the new role of Aboriginal Family Health Worker in NSW. There were around 23 Family Health Workers in 2002. Course participants must be Aboriginal Family Health Workers or Aboriginal Health Workers who work in the specialist areas of child protection, family/domestic violence and sexual assault. The course takes into account the historical, cultural, legal, social, political and personal power relations affecting Aboriginal communities. Gender issues are addressed within this context. It is recognises that child and adult sexual assault, family/domestic violence and physical and emotional abuse and neglect of children and young people impact on going community development.

It aims to develop understanding of:

- the ways in which power and control are used at an historical, political, social, cultural and personal level;
- the implications of this work in family/domestic violence, sexual assault and child protection in Aboriginal communities;
- the theories behind work in family/domestic violence, sexual assault and child protection and the implications of these to work in Aboriginal communities;
- the nature, extent and impact of child sexual assault and offender tactics on the child and other family members;
- ways of working with Aboriginal communities to address family/domestic violence, sexual assault and child protection;
- cooperative interagency approaches;
- community development strategies to address family/domestic violence, sexual assault and child abuse; and
- respectful approaches to individuals, families and communities affected by family/domestic violence, sexual assault and child abuse.

The course covers:

- ways in which power and control are used at a historical, political, social, cultural and personal level;
- implications of this for work in family/domestic violence, sexual assault and child protection in Aboriginal communities;
- theories behind work in family/domestic violence, sexual assault and child protection and the implications of these to work in Aboriginal communities;

- the nature, extent and impact of child sexual assault and offender tactics on the child and other family members;
- ways of working with Aboriginal communities to address family/domestic violence, sexual assault and child protection;
- cooperative interagency approaches;
- community development strategies to address family/domestic violence, sexual assault and child protection; and
- respectful approaches to individuals, families and communities affected by family/domestic violence, sexual assault and child protection.

Interview

An interview was conducted with Ms Mareese Terare and Ms Catherine Clarke of ECAV (16 December 2002). Information about the program is also available in print form and on the PADV website.

Ms Terare emphasised the complexity of dealing with family/domestic violence, sexual assault and child abuse in Indigenous communities. An important part of prevention is: providing education around these social issues; raising awareness around the impact on individuals and communities; understanding legislation; and supporting victims with confidence and self-esteem, thus providing them with an opportunity for people to share experiences.

The course provides an understanding of the dynamics, nature and power dynamics of family/domestic violence and sexual assault, its impact and effects, before an intervention can fully succeed.

Sexual assault was described as the biggest shame. The course provides an opportunity for people to talk about shame. It is important to understand power and power dynamics within families and communities. Trauma may occur at a young age (as an effect of family/domestic violence and sexual assault physical & emotional abuse and neglect). It may occur within families:

> The power differential around being victim/perpetrator is huge. The power dynamics set up an imbalance where victims find it difficult to talk about sexual assault. …
>
> People who know may keep silence — silences support the offenders and can have dire impact on victims …
>
> In some instances family structures are perceived as being safe. In some cases, this perception of safety is not real.

There is also a need to address parenting skills and living skills. The protective parent may also experience trauma.

Also important are all groups — which include women, men and elders — which challenge abusive behaviour such as family/domestic violence, sexual assault and child abuse.

CASE STUDY 19 — Family Life Promotion Project

Name of project
Family Life Promotion Project.

Brief description of project/program
The Family Life Promotion Project was developed as a strategy to prevent suicide among young people in Yarrabah. It was set up in 1995–6 to respond to a crisis in youth suicide at that time. The local community had undergone rapid social change with youth (15–25 years) representing 60% of the population. The project involved a 3-day training course. Forty people were trained in recognising signs of suicide. These were 'watchdogs'. The service currently employs 2 staff who are available to assist people in crisis and to develop strategies aimed at reducing suicidal tendencies. An example of a prevention strategy initiated by the program is the establishment of a men's group to discuss issues of concern to men and youth in Yarrabah.

Name of organisation conducting the project
Yarrabah Council

Description of organisation
Local Aboriginal Community Council

Type of intervention
Training workshop, counselling

Injury problem being addressed
Suicide prevention

Dates of project
The program was established in 1995 and is still operating.

Phase
The original project has been completed. The Yarrabah Men's Health Group Project has extended the work of the Family Life Promotion Project.

Scope
Local project

Geographic location
Yarrabah, Queensland

Target population
Indigenous youth 15–25 years

Funding body
State government — Queensland Health (Mental Health)

Commonwealth government — Partnerships against Domestic Violence (PADV)

Partnerships
Local elders and church leaders

Queensland Health, Mental Health Services

Other sources of information available about the project

Baird, L. and Purcey, F. Health Feasibility Study.

<http://www.Yarrabahonline.org>

Hunter, E., Reser, J., Baird, M., & Reser, P. (2001). *An analysis of suicide in Indigenous communities of North Queensland: the historical, cultural and symbolic landscape.* Canberra: Commonwealth Department of Health and Aged Care.

Future directions

The Family Life Promotion Project, a suicide prevention project, was established in 1995 and is currently operating. Further project development has occurred as a result of this early work. The Yarrabah community has worked to identify address underlying issues and has developed an integrated approach to health service management and planning. The more recently established Yarrabah Men's Health Group pilot project extends the suicide prevention work (see Case Study 5 — Yarrabah Men's Health Group Project, earlier in this volume).

Background

During the early 1990s, the Yarrabah community went through a period of high suicides. The deceased were mostly male and it appeared that the suicides were related to relationship problems, high incarceration rates, peer pressure and the lack of expression of feelings by men. There was no support group in place at the time. This led the community to seek solutions. Members of the community applied for funds to the Queensland health department to establish a program to prevent further suicides. The Family Life Promotion Program, a suicide prevention project, was established in 1995 and initially ran for 2–3 years. The program currently employs 2 workers

Interview

An interview was conducted with Mr Les Baird, Health Manager, Gurriny Yealamucka Health Service Aboriginal Corporation.

The project involved a 3-day training course. Forty people were trained in recognising signs of suicide. These were 'watchdogs'. There were no suicides for a number of years following the establishment of the program. From 1996 to 2000, the rates of suicide were reduced. However, from 2000 to 2002, there have been some suicides in unusual circumstances.

The community organisation also applied for funds to conduct a health feasibility study to address the complex health problems, that needed to be addressed to solve the problem of suicide. Yarrabah received funding from the Queensland Health Department to conduct a feasibility study to identify gaps in health services and develop a model for service delivery to address health needs.

From 1997 to 1998, gaps in services were identified. Focus groups and surveys were done but socio-emotional wellbeing was neglected. This has been addressed in subsequent projects. A Socio-emotional and Spiritual Well-being Centre of Excellence has been sent up. This is integrated with the community-controlled health service.

On 12 September 2002, the Yarrabah Health Framework Agreement. Memorandum of Understanding was signed by Queensland Health, the local community-controlled health service Gurriny Yealamucka, community health. The Yarrabah Health Partnership Forum held a local forum involving managers of local health services. The Yarrabah health action plan framework model has been developed to ensure its implementation.