

**Injury Prevention Activity Among
Aboriginal and
Torres Strait Islander Peoples
Project Report**

**Volume II: Programs, Projects and
Actions**



Dr Kathleen Clapham



Australian Government

Department of Health and Ageing

Injury Prevention Activity Among Aboriginal and Torres Strait Islander Peoples

Volume II: Programs, Projects and Actions

Report to the Australian Government Department of Health and Ageing
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Dr Kathleen Clapham

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ATSIIPAC
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INJURY PREVENTION ACTION COMMITTEE

by

Cooperative Research Centre for Aboriginal and Tropical Health

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Australian Indigenous Health *InfoNet*

New Directions in Health and Safety

Photograph: 'Two boys from the Jigalong Community, Western Australia'

Contents

ACKNOWLEDGEMENTS.....	VI
ABBREVIATIONS	VII
LIST OF FIGURES.....	VIII
LIST OF TABLES.....	VIII
OVERVIEW.....	1
METHODOLOGY.....	2
PRELIMINARY TASKS.....	3
<i>Identifying projects</i>	3
<i>Identifying key stakeholders</i>	4
<i>Research assistance</i>	4
<i>Interviews</i>	4
<i>Selection of site visits</i>	5
<i>Follow-up</i>	5
RESPONSE TO THE CONSULTATION PROCESS	5
RECORDING OF CURRENT ACTIVITY IN THE PROJECTS DATABASE.....	6
PRESENTATION OF CASE STUDIES	7
FRAMEWORK FOR ANALYSIS	7
<i>Defining 'success'</i>	7
META-ANALYSIS OF PROJECTS.....	9
NUMBER OF PROJECTS.....	9
<i>External cause of injury being addressed</i>	9
<i>Contributing factors</i>	10
ORGANISATIONS CONDUCTING PROJECTS.....	10
LOCATION OF PROJECTS	10
SOURCES OF FUNDING	11
INJURY FOCUS.....	12
POPULATION TARGETS OF INTERVENTIONS	12
INTERVENTIONS GROUPED BY POLICY FOCUS.....	13
<i>Generic injury prevention project</i>	13
<i>Transportation</i>	14
<i>Family and interpersonal violence</i>	14
<i>Drug and alcohol projects</i>	15
<i>Housing, health and safety</i>	15
<i>Early intervention/capacity building</i>	16
<i>Social and emotional wellbeing</i>	16
<i>Water safety and drowning prevention</i>	17
<i>Sports injury prevention</i>	17
TYPES OF INTERVENTIONS	17
EVALUATION OF PROJECTS	22

FINDINGS	22
NUMBER AND TYPES OF PROJECTS	22
UNDERSTANDING AND USE OF INJURY PREVENTION IN THE CONTEXT OF HEALTH PROMOTION	24
EXPERIENCES OF INJURY PREVENTION PROGRAMS	25
FUNDING	26
COST-EFFECTIVENESS OF PROJECTS	27
TRANSFERABILITY OF PROJECTS	28
MONITORING AND EVALUATING THE PROJECT	29
HOW DO YOU KNOW IF THE STRATEGIES ARE WORKING?	29
<i>Achieving a reduction in injury</i>	29
<i>The feedback from others is positive</i>	30
<i>The project has an observable positive effects</i>	31
<i>Laying the groundwork</i>	32
<i>Difficulties with measurement</i>	33
FACTORS INFLUENCING SUCCESS	34
<i>Adequate funding and resources</i>	34
<i>Community control/respect for community protocols</i>	34
<i>Community acceptability and involvement</i>	35
<i>Access to reliable information</i>	36
<i>Information sharing</i>	36
<i>Partnerships</i>	36
<i>Good organisation and management</i>	37
<i>Skilled and committed personnel</i>	38
FACTORS IMPEDING SUCCESS	39
<i>Lack of funding</i>	39
<i>Distance</i>	39
<i>Organisational issues</i>	39
<i>Problems with multiple projects in one community</i>	40
<i>Inability of projects to deal with the core issues</i>	40
<i>Lack of commitment to change from government and service organisations</i>	42
CONCLUSION: KEY ISSUES EMERGING FROM THE CONSULTATIONS	42
REFERENCES	44
APPENDIX A: LIST OF CONSULTATIONS	45
APPENDIX B: INFORMATION SHEET	46
INDIGENOUS INJURY PREVENTION ACTIVITY PROJECT INFORMATION SHEET	46
<i>Background</i>	46
<i>The projec</i>	46
APPENDIX C: QUESTIONS FOR INJURY CONSULTATIONS	48
QUESTIONS: TERMS AND DEFINITIONS	48
DESCRIBING INJURY IN INDIGENOUS CONTEXTS	48
DESCRIBING INJURY IN A SPECIFIC OR LOCAL CONTEXT	48
PREVENTING INJURIES	49
DESCRIBING AN INTERVENTION	49
EVALUATING THE EFFECTIVENESS OF AN INTERVENTION	49
OUTCOMES	50
MONITORING AND EVALUATION	50

APPENDIX D: CASE STUDIES	51
CASE STUDY 1 — TOP END WOMEN’S LEGAL SERVICE ABORIGINAL WOMEN’S OUTREACH PROJECT	52
CASE STUDY 2 — MID NORTH COAST INJURY SURVEILLANCE PROJECT	56
CASE STUDY 3 — THE CROSSING ABORIGINAL PEDESTRIAN ROAD SAFETY PROJECT, FITZROY CROSSING	60
CASE STUDY 4 — WOORABINDA COMMUNITY INJURY PREVENTION PROJECT	65
CASE STUDY 5 — YARRABAH MEN’S HEALTH GROUP PROJECT.....	68
CASE STUDY 6 — FIXING HOUSES FOR BETTER HEALTH.....	73
CASE STUDY 7 — SHOALHAVEN INJURY SURVEILLANCE AND PREVENTION PROJECT	78
CASE STUDY 8 — TANGENTYERE REMOTE AREA NIGHT PATROL	84
CASE STUDY 9 — WA WATER SAFETY PROJECTS:	88
CASE STUDY 10 — SAFE DREAMING TRAILS LINKS SCHOOLS.....	93
CASE STUDY 11 — FAMILY VIOLENCE ADVOCACY PROJECT	95
CASE STUDY 12 — COMMUNITYLIFE PROJECT (INDIGENOUS COMPONENT).....	100
CASE STUDY 13 — MEN AND FAMILY RELATIONSHIP INITIATIVE.....	104
CASE STUDY 14 — COMMUNITY EDUCATION PROGRAM FOR ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES	109
CASE STUDY 15 — INDIGENOUS “ STRONG” SAFER SPORT PILOT PROGRAM.....	113
CASE STUDY 16 — PORT YOUTH THEATRE WORKSHOP PROJECT.....	116
CASE STUDY 17 — INJURY PREVENTION IN INDIGENOUS COMMUNITIES PROJECT	119
CASE STUDY 18 — EDUCATION CENTRE AGAINST VIOLENCE (ECAV)	123
CASE STUDY 19 — FAMILY LIFE PROMOTION PROJECT	126

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Abbreviations

AHW	Aboriginal Health Worker
ALS	Aboriginal legal service
AMS	Aboriginal medical service
ATSIC	Aboriginal and Torres Strait Islander Commission
CRCATH	Cooperative Research Centre for Aboriginal and Tropical Health
CDHA	Commonwealth Department of Health and Ageing
FaCS	Commonwealth Department of Family and Community Services
FHBH	Fixing Houses for Better Health
IFVAG	Indigenous Family Violence Action Group
MNC	Mid North Coast [Injury Surveillance Project]
PADV	Partnerships Against Domestic Violence
QAS	Queensland Ambulance Service
NACCHO	National Aboriginal Community Controlled Health Organisation
NDRI	National Drug Research Institute
NQIIPP	North Queensland Indigenous Injury Prevention Partnership
PAR	Participatory action research
PHCRIS	Primary Health Care Research and Information Service
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
SMA	Sports Medicine Australia
SNAICC	Secretariat of National Aboriginal and Islander Child Care
TEWLS	Top End Women's Legal Service
UNSW	University of New South Wales

List of Figures

- Figure A Health promotion approach to primary health care 24

List of Tables

- Table A - Number of injury-related projects identified: external cause of injury 9
- Table B - Number of injury-related projects that address contributing factors 10
- Table C - Number and location of injury-related projects 11
- Table D - Number of injury-related projects: population groups targeted 13
- Table E - Number of injury-related projects: type of intervention 18
- Table F - Organisations consulted: location and contact 45

Overview

This volume presents the overview, methodology and findings of the consultation phase of the Aboriginal and Torres Strait Islander Injury Prevention Activity Project. To the extent permitted by the time frame for this project, it provides an overview of the current state of Aboriginal and Torres Strait Islander injury prevention activity, and the numbers and types of projects and their characteristics as well as a qualitative account of the experiences of key stakeholders. The discussion of the key findings and their implications, in this volume, is informed by current understanding of factors contributing to the success of Aboriginal and Torres Strait Islander health projects and programs. Four appendices provide further details of the consultations; there are nineteen detailed case studies; and there is also a separate project database.

The consultation phase involved a limited, focused consultation of major stakeholders to assess their knowledge and experiences of Aboriginal and Torres Strait Islander injury prevention activities. In order to describe the current state of injury prevention activity it was necessary: first, to conduct a broad search to identify existing injury-related projects and programs; secondly, to investigate the experiences of those involved in these prevention activities; and, finally, to make informed generalisations about factors influencing the success of their efforts. The search for relevant projects was not exhaustive; factors taken into account in deciding which projects were to be included as injury-related projects for the purposes of this study were: the broad nature of ‘injury’, the complexity of factors influencing injury in Aboriginal and Torres Strait Islander communities, and the wide range of prevention strategies employed.

What emerges from the consultation phase is that a large number of extremely diverse injury-related activities are currently being undertaken within Aboriginal and Torres Strait Islander communities, mostly driven by community-based organisations. Some of the projects identified could be considered best practice in this field. Overall, however, current injury prevention activity concentrates its efforts on a few major areas of injury. There is little activity that addresses the whole range of external causes of injury which have been identified in the Aboriginal and Torres Strait Islander population.

Methodology

The purpose of consultations was to find out what sorts of projects exist, what they entail, who is involved, why they were set up — and, most importantly, what makes a project work and why some do not work.

The approach to data collection was three-pronged, and aimed to provide both breadth and depth to the consultation findings. The project attempted to identify and document quickly all current relevant projects and programs, which target Aboriginal and Torres Strait Islander communities, that would have the effect of reducing or preventing injury. To this end, a project database was first established to record and classify as many projects as possible. Secondly, key funding or peak organisations were contacted and individuals asked about current programs and individual projects.

These first two steps uncovered a surprisingly large number of disparate but relevant projects. The review of projects did not generally include mainstream injury prevention projects aimed at the general population. Clearly, in the time available, individual programs — or even blocks of programs — may have been missed. The meta-analysis of projects provides a quantitative summary of data collected. Given the preliminary nature of this work, figures presented in this section should be read as indicative only.

The third strategy involved selecting a number of projects as case studies. Consultation around projects involved mainly phone conversations and e-mail correspondence with project workers in community organisations, and officials in relevant government and non-government agencies. Selected site visits to communities where projects were being undertaken, and meetings with those involved in projects, complemented the phone and electronic interviews. The site visits helped to contextualise and consolidate information gained from interviews. The case studies provide a valuable closer view of the people, organisations and environment in which projects are planned and undertaken. They are presented with a minimum of editorial comment or interpretation in order to represent the views of the people most involved in projects, who provided candid descriptions of how things actually worked ‘on the ground’.

The detailed accounts of projects and the general comments from stakeholders provided the basis for the analysis in the findings and conclusion. What is reported in the findings section represents what has been found consistently in the interviews with stakeholders. The direct quotes, while referring to the experience of individual projects, are illustrative of general views about issues raised by the informants.

It is important to note that it was beyond the terms of reference for this project to consult the ‘users’ or ‘consumers’ — that is, the Aboriginal and Torres Strait Islander target population of interventions — about their experiences. This feedback would normally be collected as part of the ongoing evaluation of any individual project or program.

The consultation phase was undertaken in conjunction with the search for relevant literature relating to the projects identified, including the grey literature. Direct contact with project staff and funding agencies helped to identify useful print-based and electronic resources well as a number of formal evaluations of projects. Together the interviews, site visits and available published or unpublished material provided the basis for the case studies presented in Appendix D. The full project database is provided as a separate entity.

Preliminary tasks

Identifying projects

Broad criteria

Projects were selected for the database using broad criteria, in an attempt to identify as widely as possible initiatives, projects and programs that would improve safety and lessen injury among Aboriginal and Torres Strait Islander people. It included projects with a specific injury focus, as well as those where injury may have been tangential to the intended objectives of the project.

Searches of existing literature, databases and websites

Projects were identified through searches of existing literature, projects, evaluation reports, annual reports and databases, including:

- Harrison, J., Miller, E., Weeramanthri, T., Wakerman, J., & Barnes, T. (2001). *Information sources for injury prevention among Aboriginal and Torres Strait Islander Australians: status and prospects for improvements*. Canberra: Australian Institute of Health and Welfare;
- National Drug and Alcohol Research Institute publication and online database Indigenous Australian Alcohol and Other Drugs Database <<http://www.db.ndri.curtin.edu.au/>>;
- Department of Prime Minister and Cabinet, Partnerships Against Domestic Violence (PADV) website and meta-evaluation <<http://www.padv.dpmc.gov.au/>>;
- Australian Domestic and Family Violence Clearinghouse databases <<http://www.austdvclearinghouse.unsw.edu.au/databases.htm>>;
- Department of Family and Community Services (FaCS) website <<http://www.facs.gov.au/sfcs/index.htm>>;
- Secretariat of National Aboriginal and Islander Child Care (SNAICC) website <<http://www.snaicc.asn.au/>>;
- Auseinet website <<http://auseinet.flinders.edu.au>> Social and emotional wellbeing projects;
- Beyond Blue Annual report <<http://www.beyondblue.org.au/site/>>;
- NSW Health, Drug and Alcohol Bureau audit of NSW drug and alcohol projects (Indigenous Drug and Alcohol Projects 1999–2000);
- NSW Attorney General's Department Domestic Violence Resource Link (DV Link) <<http://www.cjc.nsw.gov.au/lc/dvlink.nsf/pages/index>>;
- Flinders University, Primary Health Care Research and Information Service (PHCRIS) database of divisions of general practice <<http://150.101.248.131/cgi-bin/db.dll/home>>; and
- Transportation projects (Brice, 2000).

Public input

The public was invited to contribute to the project through an advertisement placed in the Aboriginal and Torres Strait Islander and mainstream press, and through electronic media. The advertisement requested assistance in identifying projects that address: children's injuries; sports injuries; falls and water injury; self-harm, suicide and violence; domestic violence and sexual assault; substance misuse; and road injury. It was placed in the *Koori Mail*, the *National Indigenous Times*, the *Australian*, the Indigenous Online Network and KooriNet. An information sheet (see Appendix B) and flyer were also produced and disseminated through the Yooroang Garang student network and through snowballing. An 1800 number Injury prevention hotline and an injury prevention e-mail address <injury@fhs.usyd.edu.au> were set up to receive enquires.

Identifying key stakeholders

Key stakeholders consulted for this project included:

- representatives of government and statutory bodies responsible for major initiatives;
- representatives of peak organisations;
- university researchers;
- project coordinators, managers and administrators at the community and organisational level; and
- community and project workers, including staff of Aboriginal medical services (AMSs) and Aboriginal Health Workers.

A full list of people and organisations consulted is in the project database.

Research assistance

Three Aboriginal research assistants^A and two non-Aboriginal research assistants^B were contracted to provide assistance for the consultation phase of the project. All are graduates of the Bachelor of Health Science (Aboriginal Health and Community Development) Honours (Yooroang Garang) or another program, and they have received training in qualitative research.

Interviews

From the responses gathered in the first phase, a number of individual projects were selected for further investigation, which was undertaken by the consultant and the Aboriginal and non-Aboriginal researchers. Initial phone contact was made with organisations to provide information about project and the consultants, confirm their contact name and details, request their assistance in identifying injury intervention programs and relevant people to consult with, and request a face-to-face or telephone interview.

The information sheet sent out to organisations included a statement that organisations participating in consultations would be acknowledged and invited to comment on a draft report. Interviews were undertaken either face-to-face or by phone, e-mail or fax using a series of open-ended questions (see Appendix B). Interviewees were also requested to provide additional reference or resource material related to their projects.

^A Ms Estelle Con Goo, BA Hons (Sydney), Mr Reuben Bolt, BA Hons (Sydney) and Ms Llewellyn Williams BA Hons (Sydney).

^B Ms Tara McLachlan BA Hons (Sydney) and Ms Diane Gosden MA (Hons) Macquarie.

Information was sought about:

- questions, terms and definitions;
- describing injury in Aboriginal and Torres Strait Islander contexts;
- describing injury in a specific or local context;
- preventing Injuries;
- describing an intervention (activities, funding, resources);
- evaluating the effectiveness of an intervention;
- outcomes and success of the intervention;
- monitoring and evaluation;
- benefits, community acceptability and transferability; and
- recommendations.

The process was open and conversational, and informants were encouraged to talk about aspects of projects that interested them most.

Responses to the interviews were recorded either by the interviewer taking notes, or by the interviewee providing a written e-mail response to the questions. A number of informants supplied additional print-based, electronic or video material as well as evaluation reports, where they had been carried out, which provided useful background material to the projects.

Selection of site visits

The following locations were chosen for site visits and face-to-face interviews:

- Nowra — South Coast Aboriginal Medical Service;
- Port Macquarie — Mid North Coast Area Health Service;
- Cairns — Apunipima Health Council; Queensland Ambulance Service; Queensland University Public and Tropical Health Unit; Yarrabah Community — Gurriny Yealamucka Health Services; and
- Sydney — Western Sydney Area Health Service; ATSIC.

The transcripts of the interviews, the views of those responding to the request for information, additional print, electronic and video material, and any evaluation reports all provided the basis for the nineteen case studies and the findings in this volume.

Follow-up

Prior to the submission of the draft report, contact was made with each of the organisations conducting projects included as case studies in this report. Individuals interviewed were invited to confirm details and provide any additional comments or corrections. A copy of the transcripts of interviews was returned to participants. A copy of the draft consultation report was also provided for comment, and comments received were incorporated into the final report.

Response to the consultation process

There was considerable variation in the responses of stakeholders to the consultation process. On the whole, informants responded very positively to the objectives of the project. They were very

proud of their efforts and were willing to share information about projects, reflecting their desire to contribute to worthwhile efforts to improve Aboriginal and Torres Strait Islander health.

The response to the advertisement and flyer, while not overwhelming, was useful in uncovering projects that had not been identified elsewhere. It also brought forward a range of individual viewpoints on injury problems and solutions. A number of lengthy responses came from individuals who had worked in Aboriginal and Torres Strait Islander communities and were able to provide detailed comments on particular areas of need, such as prevention and services for brain injury, sports injury and children's playgrounds as well as particular regional issues.

In regard to the individual case studies, the majority of people interviewed were satisfied with the written case study and the opportunity to review the information they had provided and for their consent to the case study to be included in the report. In one case, permission was not given and the case study was not included in the final report.

Recording of current activity in the projects database

All current and planned Aboriginal and Torres Strait Islander injury prevention activity identified by this project has been recorded and can be found in the project database (provided as a separate Microsoft Access file). The database is by no means an exhaustive list, but rather represents a snapshot of current projects: most ongoing, some recently completed, and a few planned.

The information in the database is organised using the following fields:

- reference number;
- name of project/program;
- name of organisation conducting the project;
- type of organisation — State/Territory government, Commonwealth government, Indigenous, NGO or partnerships;
- funded by — (the primary agency is listed);
- key contact and contact details;
- State/Territory;
- location — rural, urban or remote;
- scope — national, State/Territory, multi-State, regional or local;
- phase — planned, pilot, implemented or completed;
- evaluation included (little information available; included for future use);
- type of intervention — methods used;
- external cause of injury being addressed — based on standard aggregations of the ICD-9 External Cause (E-code) classification;
- contributing factors — associated with the external cause of injury;
- type of intervention — derived from the project title or description;
- target group;
- comments; and
- whether the project used a public health model (little information available; included for future use).

The database facilitates easy identification and description of aspects of the project and, used electronically, provides a mechanism for further searches along a particular parameter. For instance, all projects primarily targeting Aboriginal and Torres Strait Islander men in rural areas can be quickly identified. It should be noted that no attempt was made to indicate levels of funding for projects.

Presentation of case studies

The numbers of case studies that could be included for more detailed presentation was much limited by the time constraints of the project. The nineteen case studies, found in Appendix D, present a detailed description of individual projects as well as the views of those coordinating or managing them. The selection of case studies attempts to present a range of injury problems, describe a variety of interventions and cover a broad geographical area. Selection also depended on the availability and willingness of staff to discuss their projects within the time frame of the project as well as an indication that the project was broadly successful.

It should be noted that although a number of projects exhibit elements of best practice, the case studies do not pretend to showcase the best projects, but rather display a range of approaches to injury prevention in Aboriginal and Torres Strait Islander communities, and present a range of views.

Framework for analysis

The analysis found in the 'Findings' section of this volume is based on a broad thematic analysis of the information derived from interviews. Using a qualitative approach, an attempt has been made in the 'Findings' to present the themes which emerged during the interviews while remaining as close as possible to the statements and views of informants. For this reason the 'Findings' section makes extensive use of the direct quotes included in the individual case studies, as well as the verbal or written submissions received in response to the advertisements for this project.

Defining 'success'

One rationale for undertaking this project is to identify what is actually working in Aboriginal and Torres Strait Islander injury prevention. Knowledge of what makes a project successful in reducing or preventing injuries, and which factors contribute to a lack of success or progress, must contribute to more effective policy making, and avoid unnecessary waste of resources and energy. Being able to identify success also depends on a process of evaluation so that success or the lack of it are understood and appropriate action taken. It is also important that the further evaluation of injury prevention activity be informed by reliable data on where and how injuries are currently occurring in Aboriginal and Torres Strait Islander communities.

An overarching framework for the way in which successful injury prevention programs might work is provided by the five Principles of the Ottawa Charter <<http://www.who.int/hpr/archive/docs/ottawa.html>>:

- Building a Health Public Policy;
- Improving Community Action;
- Developing Personal Skills;
- Creating a Healthy Environment; and
- Re-orienting Health Care Services (towards prevention/promotion).

It should be noted that the same broad principles underlie the National Aboriginal Health Strategy (National Aboriginal and Torres Strait Islander Health Council, 2000), which places a strong emphasis on the central role of Aboriginal community controlled health organisations.

For Aboriginal and Torres Strait Islander injury surveillance and prevention programs, Shannon et al (2001b) recommend the following elements of a public health model for projects to make an impact in Aboriginal and Torres Strait Islander communities:

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

Shannon et al (2001a) also point out the importance of acknowledging that intervention strategies for injury surveillance and prevention projects developed and tested in one context do not necessarily work in another. Communities need to recognise and ‘own’ injury (and the antecedent causes) as an issue of importance. Community structures need to be developed in partnership with a range of relevant groups and organisations in order to raise the capacity of the community to address the injury problems.

There have also been attempts to define ‘success’ and ‘achievement’ in specific areas of injury prevention — for example, family violence prevention. The Partnerships Against Domestic Violence meta-evaluation <<http://www.padv.dpmc.gov.au/>> includes the following elements of best practice approaches for projects specifically addressing domestic and family violence:

- the need to build on the skills of people in the local community;
- protocols and guidelines for effective service delivery are needed, across agency boundaries;
- sound appropriate training for workers;
- safety of victims a key priority;
- recognition and validation of the importance of community healing;
- recognition of the importance of a family approach to dealing with violence in communities; and
- broad-based reference group of key stakeholders.

The analysis of success in the ‘Findings’ (see section later in this volume) represents the views of those consulted in this project. It should be noted that these are highly consistent with all the factors identified above.

Meta-analysis of projects

Number of projects

A total of 314 projects or programs was identified by this project, and they fell roughly into three groups. Of the total projects, less than 40 were identified as having a specific ‘injury prevention’ focus. Many others address key social or physical environmental factors that contribute to injury and safety in Aboriginal and Torres Strait Islander communities. The majority of these types of projects address either family violence or issues related to alcohol, or both.

Recognising the importance of adopting long-term strategies to the widespread and serious injury and safety issues currently faced by Aboriginal and Torres Strait Islander communities, the project also identified a third group of projects with a secondary or long-term safety outcome. These projects were unlikely to have a specific injury objective and were most likely to be funded under the headings of ‘early intervention’, ‘capacity building’ or ‘social and emotional wellbeing’.

By employing a broad definition of ‘injury prevention’, the project uncovered a large number of projects. The list of projects in Appendix A is by no means exhaustive of all possible projects that could have been included, but rather a first attempt at compiling a list of Aboriginal and Torres Strait Islander Australian injury-related projects. The constantly changing nature of this field and the short-term nature of many projects mean that to develop and maintain a more accurate database would need to be resourced separately as an ongoing project.

External cause of injury being addressed

More than half the projects identified (see Table A) focused on a specific external cause, most commonly interpersonal violence.

• Table A - Number of injury-related projects identified: external cause of injury

External Causes	State/Territory											Total
	ACT	AUS	Multi-State	NSW	NT	Qld	Qld/TSI	SA	Tas	Vic	WA	
Drowning and submersion											3	3
Fires/burns/scalds		2		1								3
Interpersonal violence			6	20	17	19	1	8	2	9	23	105
Multiple external causes				5	1	3		1				10
Self harm	1			1	7	8		1		4	14	36
Transportation			3	2	1	2		1			16	25
Not specified		1	3	20	47	8	1	8		9	35	132
Total	1	3	12	49	73	40	2	19	2	22	91	314

Contributing factors

- Table B - Number of injury-related projects that address contributing factors

Contributing Factor	State/Territory											Total
	<i>ACT</i>	<i>AUS</i>	<i>Multi-State</i>	<i>NSW</i>	<i>NT</i>	<i>Qld</i>	<i>Qld/TSI</i>	<i>SA</i>	<i>Tas</i>	<i>Vic</i>	<i>WA</i>	
Alcohol				6	38	9	1	4		6	31	95
Alcohol and other drugs				4	1			3		2	1	11
Alcohol and volatile substance abuse				1	1	2					3	7
Volatile substance abuse				2	1						3	6
Not specified	1	3	12	36	32	29	1	12	2	14	52	195
Total	1	3	12	49	73	40	2	19	2	22	91	314

Less than half the projects (see Table B) addressed a contributing factor to injury and these were commonly alcohol or other substance use projects.

Organisations conducting projects

It should be noted that no attempt was made to distinguish projects on the basis of size, either in terms of funding received or population serviced by the project. Nevertheless, it would appear that the majority of the projects are local, community-based projects conducted by Aboriginal and Torres Strait Islander organisations. A large number of projects was funded and conducted by State/Territory government departments, and many projects involved collaborative partnerships with more than one organisation.

Location of projects

With the exception of the ACT, projects identified were located in all of the States and Territories of Australia, with most injury-related activity concentrated in Western Australia and the Northern Territory (see Table C).

• Table C - Number and location of injury-related projects

State/Territory	Total
ACT	1
Australia	3
Multi-state	12
NSW	49
NT	73
Qld	40
Qld/TSI	2
SA	19
Tas	2
Vic	22
WA	91
Total	314

Note: TSI = Torres Strait Islands

The vast majority of projects was found in rural or remote areas. Despite the fact that the largest percentage of Australia's Aboriginal and Torres Strait Islander population is concentrated in urban areas, only around 20% of projects were located in urban areas.

Sources of funding

Although the amount of funding for each project is included in the project database, it should be noted that there is considerable variation in funding provided to different projects. The majority of projects receives funding from government bodies, notably:

- Commonwealth Department of Health and Ageing (CDHA);
- Aboriginal and Torres Strait Islander Commission (ATSIC);
- Commonwealth Department of Prime Minister and Cabinet (Office of the Status of Women);
- Commonwealth Department of Family and Community Services (FaCS);
- State/Territory health departments; and
- NSW Department of Aboriginal Affairs (DAA).

Sources of funding for individual projects included in the project database are not complete, particularly those related to drug and alcohol projects and night patrols, for which information has been derived from Gray et al. (2002). However, it is clear from information from Attorney's-General departments that these departments are funding many of these programs, for example, the National Crime Prevention Strategy and related State/Territory programs.

In fewer cases, private bodies provided funding, and sometimes in-kind support, such as a vehicle. Some organisations were able to pool resources to make a project viable. For example, the

Queensland Department of Emergency Services' Community Education Program for Aboriginal and Torres Strait Islander Communities, which provides in-service and training in first aid for Aboriginal and Torres Strait Islander people in Cape York and the Torres Strait, is supported by the local health service vehicle and land and sea management resources.

Injury focus

The injury prevention projects identified in this project can be broadly classified into three types by their intervention target: projects that address a specific injury issue; projects that address two or three issues; and multi-issue initiatives.

The vast majority of projects identified, aimed to prevent injury from a specific external cause such as:

- interpersonal violence (105 projects);
- transportation (25 projects);
- housing safety (2 major programs with multiple projects);
- suicide and self-harm (36 projects);
- drowning (3 projects); and
- sports injury (1 project).

A smaller number of projects linked injury issues in one project. The Torres Strait Water Safety Project, for example, addresses the dual issue of alcohol-related drowning in the Torres Strait. The Family and Domestic Violence Prevention and Intervention Program, run by the Krurungal-Aboriginal and Torres Strait Islanders Corporation for Welfare, Resource and Housing in Queensland, is similar to a number of projects that link family violence with alcohol or substance misuse, and occasionally to men's or women's health.

Projects using multi-issue initiatives involve several interventions operating at different levels. Notable examples include: the Injury Surveillance and Prevention Projects conducted by NSW Health in collaboration with community partners in Shoalhaven, the Mid North Coast, and Western Sydney; and two Queensland projects, the Woorabinda Community Injury Prevention Project and the Injury Prevention in Indigenous Communities Project. In these projects, the identification and reduction or prevention of injury is the major focus, with a broad approach to possible interventions.

Population targets of interventions

The majority of projects targeted Aboriginal and Torres Strait Islander communities or families, with a significant number of projects targeting youth (see Table D).

• Table D - Number of injury-related projects: population groups targeted

State / Territory	Indigenous families	Elders	Indigenous Communities	Women	Boys	Youth	Children	Community Workers	Men	Adults	People with disabilities	Offenders / inmates
ACT	0	0	1	0	0	0	0	0	0	0	0	0
Australia	0	0	2	0	0	0	0	0	0	0	0	0
Multi-State	4	0	6	0	0	1	1	1	0	0	0	0
NSW	9	3	18	1	2	6	8	1	2	0	1	0
NT	9	2	23	2	0	12	2	1	4	5	0	2
Qld	14	0	10	4	0	4	3	1	5	0	0	3
Qld/TSI	0	0	2	0	0	0	0	0	0	0	0	0
SA	3	0	7	3	0	3	3	0	1	0	0	0
Tas	1	0	2	0	0	0	0	0	0	0	0	0
Vic	5	0	11	0	0	2	1	0	0	0	0	0
WA	13	1	35	1	0	17	7	1	9	0	0	1
Total	58	6	117	11	2	45	25	5	21	5	1	6

Note: TSI = Torres Strait Islands

Specific groups within the population that were targeted by projects include those at risk of suicide, self-harm or misuse of drugs or alcohol, drivers and pedestrians.

There are some notable absences in the groups targeted for injury prevention activity. Those groups much less likely to be targeted in projects include people with physical or mental disabilities, children to some extent and male victims of violence. It was pointed out by a number of those consulted that these vulnerable groups are at much higher risk of injury. The lack of project activity specifically targeting these groups suggests that their considerable needs may be currently neglected.

This is highlighted in the lack of interventions that address violence between males. Despite the fact that interpersonal violence is clearly addressed in so many projects, violence occurring outside the home, particularly between men, receives surprisingly little attention.

Interventions grouped by policy focus

Generic injury prevention project

Of the 314 programs identified as projects seeking to improve the safety and lessen injury among Aboriginal and Torres Strait Islander people, only a few focused explicitly on preventing injury. Projects such as the Shoalhaven Injury Surveillance and Prevention Project, the Mid North Coast Injury Surveillance Project, the Western Sydney Injury Surveillance Project, the North Queensland Injury Prevention Project, and the Woorabinda Community Injury Prevention Project Inquiry — mostly funded by State health departments — have addressed injury as the primary focus.

These projects utilised the principles of risk management and injury prevention by identifying the underlying issues in injury, including socioeconomic issues, and depended on a high degree of community support for their success.

The development of appropriate models for Aboriginal and Torres Strait Islander injury prevention and the establishment of effective partnerships are important aspects of projects using a multi-issue approach. The establishment and maintenance of working partnerships among communities and stakeholder organisations is a key feature of the Injury Prevention in Indigenous Communities Project currently being conducted by the North Queensland Indigenous Injury Prevention Partnership (NQIIPP).

Transportation

Transportation injuries have been identified as the leading cause of injury mortality among Aboriginal and Torres Strait Islanders (see Volume I: Current Status and Future Directions). Most of the transportation projects identified are located in Western Australia and address a range of road safety issues including breath testing, seat belts and pedestrian injury, strategic planning and resource development. Approaches to road safety range from the production of printed information, to promoting the use of cages on utility-type vehicles, to a holistic approach to address numerous risk factors for pedestrian injuries. The RoadWise project in Fitzroy Crossing, for example, focused primarily on reducing the large number of pedestrian injuries and fatalities recorded in the locality. The project, conducted by RoadWise and a number of collaborative partners, used multiple strategies to increase community involvement in the project. 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 by encouraging pedestrians to be more visible to motorists at night (see Appendix D: Case studies).

Family and interpersonal violence

As previously stated, the majority of Aboriginal and Torres Strait Islander projects identified in the project addresses the issue of domestic or family violence. Most are funded through the Partnerships Against Domestic Violence strategy. This national strategy involves ongoing evaluation through its meta-evaluation program. An overview of funded projects, as well as aspects of 'best practice' for projects related to Aboriginal and Torres Strait Islander family violence, is identified in the meta-evaluation bulletins.

Projects under PADV include: the Rural and Remote Domestic Violence Initiative, funded through the Commonwealth Department of Family and Community Services (FaCS), which established five pilot projects and has approved 20 new services in rural and remote areas; Support Services for Indigenous Australians, also funded through FaCS, delivers counselling, relationship education and intervention services; the Family Violence Advocacy Projects, funded through ATSIC, comprising the Apunipima Cape York Health Council (Cairns Qld) and Bega Garbarrunga Health Service, (Kalgoorlie, WA); Training for Agencies working with Indigenous Women, also through ATSIC, includes the Far North Indigenous Consortium for Social and Emotional Health (Cairns) and the Top End Women's Legal Service (Darwin). PADV has also commissioned research on attitudes to domestic violence in Aboriginal and Torres Strait Islander, and culturally- and linguistically diverse communities.

Since 1998, ATSIC has funded direct service delivery to address family violence. Under its Family Violence Legal Prevention Program, thirteen Family Violence Prevention Legal Services (FVPLS) have been set up nationally to assist communities affected by violence.

One notable family violence project, which could be applicable to any Aboriginal or Torres Strait Islander community, is the Apunipima Health Council's Family Violence Advocacy Project. After extensive community consultation, a three-pronged model was developed to address the problem of family violence in the Cape York region. It involved local level community workshops aimed at building self-esteem; a local service provider forum to facilitate exchange of information between community members and service providers; and a monthly regional meeting of government and non-government organisational representatives.

Drug and alcohol projects

Aboriginal and Torres Strait Islander projects with a drug and alcohol focus have been reviewed recently in a useful resource by Gray et al. (2002)^C. This report identified a total of 277 alcohol or other drug intervention projects conducted by or for Aboriginal and Torres Strait Islanders. The majority of the projects (266 or 81%) were conducted by 177 Aboriginal and Torres Strait Islander community-controlled organisations. Of the 277 projects:

- 57 provided a mix of health promotion services, such as sporting and recreational activities as an alternative to or diversion from alcohol or other drug use, and a small number of community development projects; and
- 93 provided acute intervention services — including 68 night patrols, 22 sobering-up shelters, one combined patrol and shelter, and two multi-service projects.

Most of the night patrols were located in the Northern Territory (33) and Western Australia (21), and accounted for the larger numbers of projects in those jurisdictions.

Some State/Territory government mainstream initiatives in alcohol misuse, such as the Northern Territory's Living With Alcohol program introduced in 1991, have had an impact in areas with a large Aboriginal and Torres Strait Islander population. This program was introduced specifically to reduce the personal, social and economic costs of alcohol misuse and abuse in the Northern Territory. The program is based on the principles of harm minimisation and has developed, implemented and coordinated a comprehensive range of strategies to reduce alcohol-related problems and build on existing programs.

Housing, health and safety

The two major housing safety initiatives identified involve multiple local housing projects with a focus on safety and health in rural and remote communities. No urban projects were identified. The Fixing Houses for Better Health project, conducted by Health Habitat and funded by ATSIC and the Department of Family and Community Services (FACS), aimed to maximise the safety and health of 1000 Aboriginal and Torres Strait Islander houses nationally (see Appendix D: Case studies). The specific injury problems addressed included: electrical safety, gas safety and fire safety; any safety issues relating to structural collapse (e.g. stairs, handrails); and burns from hot water. Child safety was of particular concern in relation to all of these areas.

^C D. Gray, B. Sputore, A. Stearne, D. Bourbon and P. Stempel (2002) *Indigenous Drug and Alcohol Projects 1999-2000*. Australian National Council on Drugs Research Paper #4. Canberra: Australian National Council on Drugs. This publication complements the National Drug Research Institute's substantial online database <<http://www.db.ndri.curtin.edu.au/>>.

Within NSW, Housing for Health projects have been undertaken in at least eighteen communities in rural and remote areas. These projects aim to assess, fix and maintain health hardware so that houses are safe and the occupants have the ability to carry out healthy living practices. Housing issues addressed include leaking taps, unsafe power, inadequate hot water and inoperative showers. The program does not address issues that are not directly linked to health improvement (NSW Health, n.d.).^D

Early intervention/capacity building

A large number of projects and services have been funded under the FaCS Stronger Families and Communities Strategy, which will continue until the end of 2004. To date, 127 of the total of 800 projects funded under the strategy are in Aboriginal and Torres Strait Islander communities. Selected projects have been included in the projects database. The evaluation of these projects began early in 2003. A number of these projects address domestic violence; others address youth crime, leadership and relationships. A major focus of the strategy is on early intervention. The major categories for funding are early intervention, parenting, relationships, and leadership.

Based on the view that often communities were seen to have good ideas and needed short-term funding, FaCS funding is seen as assistance to get things started or initiate new ideas. For the most part FaCS projects funded under the Stronger Families and Communities Strategy are not seen as injury prevention but rather as early intervention and capacity building. Nevertheless there are some clear overlaps, as in these three examples.

1. A vacation care program was developed from a desire to help children stay out of trouble. The feedback at the end of the Christmas break was that, for first time, there were no incidents of vandalism. Although there cannot be a direct causal attribution made towards the program, it may indicate that the program reduces the prevalence of risky behaviour that may lead to injury.
2. A project funded at Bagot community in Darwin provided breakfast in an equipment-safe kitchen. This meant a safe environment for mothers, as well as education on nutrition.
3. The Tennant Creek Youth and Community Safety Project addressed youth issues and crime prevention. While this is not direct injury prevention, it helps to create an environment where injuries are less likely to occur.

Social and emotional wellbeing

A number of projects broadly addressing social and emotional wellbeing have been funded through the widely-publicised Beyond Blue initiative. Although all projects have not been systematically recorded at this stage, one example is the partnership between the Top End Division of General Practice and Batchelor Institute, which is working to improve the delivery of primary mental health care and promotion to remote Aboriginal and Torres Strait Islander communities in the Northern Territory.

^D NSW Aboriginal and Torres Strait Islander Plan for the Prevention and Management of Substance Misuse Regional Program Audit.

Also under the broad heading of social and emotional wellbeing is the Commonwealth Department of Health's National Youth Suicide Prevention Program, which has funded a number of important suicide prevention initiatives. A major national initiative under this strategy is the Aboriginal and Torres Strait Islander component of the CommunityLIFE Promotion project, which began in 2003. Based on the LIFE framework, the national framework for suicide prevention activities in Australia, the project involves direct practical assistance to enhance community participation and skills in planning, implementing and evaluating safe, effective and sustainable life promotion programs.

Water safety and drowning prevention

The three drowning prevention and water safety projects identified were all located in Western Australia and were largely education programs targeting young people. The Drowning Prevention Program for Aboriginal Health Workers throughout Rural and Remote Western Australia project equipped 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 will introduce the Royal Life Saving Society's Swim and Survive program within Aboriginal and culturally- and linguistically diverse groups in Western Australia.

Sports injury prevention

There is apparently little activity around preventing sports injuries suffered by Aboriginal and Torres Strait Islanders, although the issue is identified in other studies as a potentially important area for intervention (Royal, 2002). Only one sports injury project was identified, targeting Aboriginal people in a remote Northern Territory community. This pilot project, conducted by Batchelor Institute (an institute of higher education) in conjunction with Indigenous Sports Program (Australian Sports Commission) and Sports Medicine Australia (NT) is planned to be run in a number of other remote communities in 2003.

Types of interventions

The database of projects reveals that no single approach to injury-related problems is prevalent. The project uncovered a very broad range of interventions currently being used in Aboriginal and Torres Strait Islander communities. This range of interventions possibly reflects the diversity both of the injury field and of the Aboriginal community, which require a diversity of intervention approaches. It should be noted that in collecting the numbers of projects that use each major type of intervention (see Table E), information was not available for every project.

• Table E - Number of injury-related projects: type of intervention (Part 1)

State/Territory	Injury Surveillance	Safety audit/ Repairs	Road Safety Campaign	Education programs	Resource development	Awareness/ Media	Legal/ Advocacy	Night Patrol	Shelters
ACT	0	0	0	1	0	1	0	0	0
Australia	0	2	0	0	0	1	0	0	0
Multi-State	0	0	3	2	2	4	0	0	0
NSW	4	1	2	4	2	4	3	8	0
NT	0	0	1	6	2	3	6	33	2
Qld	2	0	2	12	5	5	1	3	3
Qld/TSI	0	0	0	1	0	0	0	0	0
SA	1	0	1	7	1	0	1	5	2
Tas	0	0	0	0	0	0	0	0	0
Vic	0	0	0	3	0	4	1	2	6
WA	0	0	16	14	3	5	3	22	9
Total	7	3	25	50	15	27	15	73	22

Note: 1 Part 2 of this Table, which includes seven more categories of injury-related intervention, appears below

2 TSI = Torres Strait Islands

• Table E - Number of injury-related projects: type of intervention (Part 2)

State/Territory	Arts/ Theatre/ Music	Youth Activities	Counselling/ Personal Skills/ Leadership/ Relationships	Cultural Programs/ Camps	Early Intervention/ Parenting	Community Development/ Capacity Building	Policy/ Planning/ Research/ Evaluation
ACT	0	0	1	0	0	1	0
Australia	0	0	0	0	0	0	0
Multi-State	1	0	0	2	1	0	1
NSW	1	3	2	4	8	6	1
NT	0	4	6	1	13	4	4
Qld	0	1	1	4	3	9	2
Qld/TSI	0	0	0	0	0	0	0
SA	1	3	1	2	1	1	0
Tas	0	0	0	0	0	1	0
Vic	1	1	4	3	2	2	0
WA	3	8	7	7	1	7	1
Total	7	20	22	23	29	31	9

Note: 1 Part 1 of this Table, which includes nine more categories of injury-related intervention, appears above

2 TSI = Torres Strait Islands

Injury surveillance

Broad-based Injury Surveillance projects (see Part 1 Table E) make up only a small percentage of approaches to an intervention. These projects have taken a more systematic approach to identifying and preventing injury. They draw from existing data or develop systems to record data to identify the causes of injury within Aboriginal and Torres Strait Islander communities and then, in collaboration with communities and organisations, develop strategies to address these causes.

Safety Audit/Repairs

The approach to housing safety taken by the Fixing Houses for Better Health and NSW Housing for Health projects is to assess, fix and maintain health hardware so that houses are safe and the occupants have the ability to carry out healthy living practices.

Road safety campaign

Road safety interventions encompass a variety of approaches, including: education and media campaigns, education, breath-testing and restraint use.

Education programs

Projects that intervene through education and training include: an accredited training program such as the Certificate IV in Family/Domestic Violence and Sexual Assault (Aboriginal Family Health Education) offered by Education Centre Against Domestic Violence (ECAV) in NSW (see Appendix D: Case studies); and projects aimed at reducing sports injuries (see Indigenous “STRONG” Safer Sport Pilot Program in Appendix D: Case studies).

The Indigenous “STRONG” Safer Sport Pilot Program 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 by Batchelor Institute of Indigenous Tertiary Education in conjunction with these two organisations, and then piloted in Yirrkala community in north-east Arnhem Land, NT, in December 2002.

The three drowning prevention projects all had an important element of education and training embedded in them. The Remote Aboriginal Swimming Pools Project involved the construction 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 will introduce a successful mainstream project, the Royal Life Saving Society’s Swim and Survive Program, to Aboriginal and culturally- and linguistically-diverse groups in Western Australia. This initiative follows previous successful initiatives in water safety in remote communities (see Appendix D: Case studies: WA Water safety projects).

A few health education projects — for example, the Noarlunga Health Service’s Safe Dreaming Trails Links Schools project — have focused on school education. This creative project led to the production of a CD-ROM, and involved children in traditional storytelling and artwork as part of the identification of hazards in the school environment. Although the project targeted both Aboriginal and non-Aboriginal children in the classroom, the strong cultural element was intended to address reconciliation between Aboriginal and non-Aboriginal people.

Numerous projects use education within a broader strategy that may also include counselling, awareness-raising or cultural activities.

Resource development

Other projects have raised awareness by developing and distributing resources such as print-based materials, pamphlets and posters and resource booklets, videos and CD-ROMs. These strategies are utilised in a broad range of projects with different injury foci and target groups.

Awareness campaign/media

A number of projects have been designed around a broad-based campaign to raise awareness about an issue. A major national program ‘Walking into Doors’ involved a media campaign using well-known personalities Archie Roach and Ruby Hunter to promote greater awareness of the impact of domestic violence in Aboriginal and Torres Strait Islander communities.

Legal services/advocacy

ATSIC has been the major organisation supporting a number of very successful legal and advocacy services, particularly around developing approaches to family violence that meets local needs. The Top End Women’s Legal Service (TEWLS) Aboriginal Women’s Outreach Project in Darwin has been a highly successful project involving the employment of Community Legal Workers in Darwin and local Aboriginal and Torres Strait Islander communities.

Night patrols

Night patrols have been one of the most successful approaches that address alcohol and other drugs in relation to violence. The majority of night patrols is located in the Northern Territory and Western Australia, and accounted for the larger numbers of projects in those jurisdictions (Gray et al., 2002).

More recently other states have also established night patrols. In NSW, for example, trials of Aboriginal night patrols — which support volunteer community members to pick up young people ‘at risk’ and transport them to their home or to some other safe place — were conducted in four areas around NSW (Kempsey, Wentworth, Forster and Narrandera). Transport services are also provided to alcohol- and drug-affected people who require them, in keeping with the *Intoxicated Persons Act*. An evaluation of the program showed that night patrols were a highly successful crime prevention strategy (NSW Health, n.d.).

Shelters

Like night patrols, sobering-up shelters are concentrated mainly in Western Australia and the Northern Territory. They often provide an alternative to police detention for intoxicated people who may do harm to themselves or others.

Personal safety shelters are set up to offer refuge to women and children who are at risk or victims of domestic violence. They are often incorporated into an existing service — such as the Women’s Mobile Outreach, Broome — and are integrated with other types of interventions such as counselling, advocacy and education.

Arts/theatre/music

A few projects were highly creative, involving the arts. Walking Into Doors used music and well-known personalities Archie Roach and Ruby Hunter in a highly publicised media campaign to help address family violence. The Port Youth Theatre Workshop Project involved two pilot projects with Aboriginal and Torres Strait Islander 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. In this project, the arts and health came together in a fun, exploratory and safe way. Other projects linking the arts to family violence are the Kamilaroi Music Against Violence Project and the Yirra Yaakin Noongar Theatre Project.

Youth activities

Other youth-based approaches include youth drop in centres, such as the one being developed by the Bardi Youth Project in Western Australia, and funded by the National Suicide Prevention Program.

Counselling/personal skills development

Counselling and personal skills development were often combined with other strategies, particularly in projects that address family violence and self-harm. The Men's Outreach Service in Broome, for instance, offers: a centrally-located 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.

Cultural programs/cultural camps

The development of a cultural component to intervention projects very often takes the form of camps for men, women, children or youth. This environment is conducive to elders and other community workers delivering community education workshops.

Early intervention/parenting

Projects utilising early intervention approaches attempt to enhance the capacity of families to deal with a range of health and social issues. Projects have various foci, including improving relationships and parenting skills.

Community development/capacity building

A broad-based community development approach to injury prevention and safety promotion may utilise any number of the intervention strategies mentioned above. A notable example of this approach is the Yarrabah Men's Health Group Project, which uses the principles of community development to develop a broad range of strategies — including personal skills development; leadership and parenting, employment and business; education and training; and cultural pride — to address a range of health and social issues, including suicide prevention, self-harm, domestic violence. This approach is expected to have both a short- and long-term impact on high injury rates in that community, and it involves a high degree of community involvement acceptance and leadership.

A number of projects build the capacity of communities through the development of networks and partnerships.

Policy/planning/research/evaluation

This category includes all activity associated with strategic planning and policy development, as well as research and evaluation projects.

Evaluation of projects

Few of the projects identified included a formal evaluation component as part of the funded project. Nevertheless evaluation had usually occurred, or was planned to occur, using either formal or informal means in almost all of those projects included in Appendix D: Case studies.

Some funding bodies have undertaken a formal evaluation of a number of projects and have produced easily accessible reports. Partnerships Against Domestic Violence produced a meta-evaluation of its projects. That meta-evaluation is available online at <www.dpmc.gov.au/osw/padv/index.html>. ATSIC has conducted an evaluation of its Family Violence Prevention Legal Service Units (see Top End Women's Legal Service Aboriginal Women's Outreach Project in Appendix D: Case studies). Family and Community Services is planning an evaluation of the Stronger Families and Communities Strategy for early 2003. In NSW, a training and evaluation program is now being developed for a rollout of night patrols.

Findings

Number and types of projects

This project identified a surprisingly large number of current, recent or planned activities that may have an impact on reducing of the high rates of injury prevalent in Aboriginal and Torres Strait Islander communities. There is a mismatch, however, between the projects currently occurring and the identified causes and contributing factors to injuries in Aboriginal communities.

Activity appears to be strongly concentrated on a few major causes of injury, rather than the whole range of external causes of morbidity and mortality that has been identified in the Aboriginal and Torres Strait Islander population. Relatively few projects focused on preventing injury or death from transportation or drowning, and only one sports-injury prevention project was identified.

The vast majority of projects identified by the project are concerned with either family violence or alcohol or both, with a focus primarily on the social or behavioural aspects of violence and abuse and the consequences of these problems. A significant number of projects have an early intervention or capacity-building focus that addresses issues such as personal and family relationships, developing parenting skills, social activity and community leadership. Despite the apparent high level of activity, the area of family violence is thought to be under-resourced. Consultations with workers indicated that current initiatives are positive but are far from reaching all of those who require their services.

Of the 314 projects identified, relatively few projects had a specific objective to reduce or prevent injury (although this partly reflects our sampling method). A number of promising projects in this category draw from existing data or develop systems to record data to identify the causes of injury within Aboriginal and Torres Strait Islander communities and then, in collaboration with communities and organisations, develop strategies to address these causes.

A number of key projects addressed a particular underlying factor, such as housing, which impacts on many aspects of health and safety as well as on the social and emotional wellbeing of families. Housing safety projects not only have the potential to prevent injuries arising from inadequate, poorly-constructed and badly-maintained houses, but also to improve other aspects of safety including interpersonal violence. One informant commenting on a women's outreach service made the following recommendation:

Ensure all Aboriginal people have adequate housing (this is one of the biggest problems contributing to child sexual abuse, family violence, injury and consequently, psychological damage).

Most projects are in rural or remote areas. Very little injury prevention activity was identified in urban areas, despite the larger proportion of the Australian Aboriginal and Torres Strait Islander population residing in a small number of cities and towns.

There is a very strong commitment to community-driven projects, where activities are conducted by local Aboriginal and Torres Strait Islander community organisations. In this respect, Gray et al's (2002) comments on the vast number of drug and alcohol projects apply equally to projects in other injury-related areas:

'The sheer number of projects indicates that Indigenous people are vitally concerned about problems of alcohol and other drug misuse within their communities. More importantly they are doing something about the problem — in some cases with no outside funding at all, and in most cases supplementing grant funding with voluntary community work'.

There is a strong emphasis, in the projects identified, on partnerships between local Aboriginal and Torres Strait Islander community organisations, universities, State/Territory and Commonwealth government funding bodies, and non-government organisations. While the commitment to partnerships is, for some, a requirement for the funding body, for others it is an effective way of achieving sufficient support for effective self-determination and community control.

Most projects target either the Aboriginal and Torres Strait Islander community or Aboriginal and Torres Strait Islander families. Many projects focus on the needs of the individual client or family group through counselling, advice and advocacy services. A smaller number target specific groups such as women, men, youth and children. Few projects target the elderly or those with a physical or mental disability.

The project identified an extremely wide range of strategies to address injury issues. Strategies such as night patrols and sobering-up shelters and women's shelters have an established track record as highly successful ways of dealing with the wide range of violence- and alcohol-related problems in Aboriginal and Torres Strait Islander communities. Community education, awareness and training of key community personnel were also popular approaches. Many projects use a variety of strategies to address one or more issues.

Understanding and use of injury prevention in the context of health promotion

The question of whether a particular project or group of projects could be considered as ‘injury prevention’ activity was discussed primarily with individuals responsible for funding programs. Projects framed in terms of ‘community development’ can have an extremely important effect on injury rates in the longer term by building community capacity and addressing social and economic factors underlying the widespread nature of injury in Aboriginal and Torres Strait Islander communities.

At the individual level, the results of ‘early intervention’ projects that address fundamental personal issues — such as parenting, relationships and leadership — may determine rates of injury in the long term, but the impact will not be immediate. Similarly, the effect on injury rates of projects that address the social and emotional wellbeing of individuals and communities is extremely difficult to determine. Moreover, as many recent projects have not yet been evaluated, it is too early to comment on the impact of these broader approaches in reducing rates of injury in Aboriginal and Torres Strait Islander communities.

A health promotion approach to primary health care distinguishes types or layers of intervention in terms of prevention, early intervention, treatment and continuing care (see Figure A).

- Figure A Health promotion approach to primary health care



Source: Commonwealth Department of Health and Aged Care, 2001a:7 adapted from Mrazek & Heggerty, 1994

This model (see Figure A on previous page) can easily be adapted to describe the spectrum of injury prevention. What it illustrates is that there is a continuum of activities that can be broadly classified as prevention, early intervention; intervention and continuing care, and the lines between them are often blurred. ‘Prevention’ programs are interventions that seek to minimise risks associated with preventable injury. They can include health promotion activities, personal injury prevention and even community development. ‘Treatment’ is usually taken in response to a problem once it has occurred. However, ‘treatment’ — for example psychological counselling for perpetrators of violence — can also lead to a reduction in the harmful behaviour that caused the injury in the first place. ‘Acute interventions’ — for example, night patrols and refuges, which aim to prevent intoxicated persons from harming themselves — can also prevent injury occurring.

Many projects employ multiple interventions that go across the spectrum of health promotion approaches. The Men and Family Relationship Initiative project in Broome, for example, involves a town-based 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. The Injury Prevention in Indigenous Communities Project (NQIIPP) addresses the whole spectrum of treatment through to prevention, by looking at key injuries in each age group. Similarly, night patrols are multi-faceted and flexible interventions that span the spectrum of interventions:

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. (NT Night Patrol)

Experiences of injury prevention programs

Without exception, those consulted were enthusiastic about the interest the Department of Health and Ageing is taking in the area of injury prevention and safety in Aboriginal and Torres Strait Islander communities. All saw injury and safety as priorities for Aboriginal and Torres Strait Islander communities. Those involved in projects were very proud of their efforts and willing to share their experiences, good and bad.

The Best Practice Database provides examples of excellent and innovative projects in Aboriginal and Torres Strait Islander communities. Many of these projects — such as the Yarrabah Men’s Health Group Project, Community Education Program for Aboriginal and Torres Strait Islander Communities, Fixing Houses for Better Health projects, and Top End Women’s Legal Service (TEWLS) Aboriginal Women’s Outreach Project — have been developed over many years and have strong community support. A number of very promising planned initiatives — such as the Aboriginal and Torres Strait Islander component of the CommunityLIFE Project and the Drowning Prevention Project — parallel existing successful mainstream programs.

One of the major challenges in prevention projects in Aboriginal and Torres Strait Islander communities is the cost of running projects, particularly in remote and large rural areas. Not only the geographical spread of communities and the lack of communication and other infrastructure, but also the high level of personal support from staff which is needed in these communities, adds a substantial burden to any project budget. This is particularly burdensome to organisations that are committed to principal Aboriginal and Torres Strait Islander community involvement and control of projects:

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 eight women working from the four communities get a low wage directly from us. (Northern Territory Women’s Legal Service)

It should also be noted that interventions employed for a particular purpose could have a planned or unplanned benefit on other aspects of Aboriginal and Torres Strait Islander community health and wellbeing. For instance, the WA Water Safety Project, with a focus on drowning prevention, also had an impact on educational attendance:

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. (WA Water Safety Project)

When evaluating projects, it is important not to be inflexible when comparing outcomes to stated objectives. As one informant pointed out, sometimes facilities are not used in the way originally intended. This may be seen as a failure, but the change in emphasis of the project may have other beneficial outcomes for the community. Projects can evolve as priorities change and new needs are identified, and can learn from their successes and failures.

The Yarrabah Men’s Health Group Project, for example, had a primarily counselling and training focus to begin with. The community has moved to adopt a broad community development approach to try to build community capacity and skills development of individuals in order to address the needs of men and women in the community. This approach appears to be having a good deal of success.

Sharing information about injury and injury prevention is the focus of a number of significant projects. The CommunityLIFE Promotion project, for example, will pass on, through the development of a web-based Good Practice Suicide Prevention Resource, what is already known about preventing suicide, as direct practical assistance to those implementing life promotion programs in Aboriginal and Torres Strait Islander communities. The Injury Prevention in Indigenous Communities Project is involved in mapping out information about injury and injury prevention in north Queensland on the basis of current activity, organisations involved, successes and failures, and planned projects. This project aims to enhance information systems so that comprehensive information will be available to community organisations, funding bodies and policy makers. Other projects, such as the Education Centre Against Violence (ECAV), share information, knowledge and skills in domestic violence prevention through formal accredited training courses.

Funding

It should be noted that the present project did not attempt to record the actual amount of funding received for each project. What was noted as one of the major concerns of those consulted, however, was the lack of certainty about ongoing funding for projects that were considered as worthwhile and meeting an urgent need.

Concern over the lack of ‘recurrent’ government funding is widespread in the community sector. As Gray et al (2002:16) point out, as a consequence of moves by governments to program-based budgeting in the 1980s and output-based budgeting in the latter part of the 1990s, the distinction between recurrent and non-recurrent funding is misleading, as all government project grants are made for finite periods and renewal is subject to annual review.

Nevertheless, the reliance on one-off grants places an administrative burden on organisations, which appear to be continuously in pursuit of government and other funds in order to carry out projects to ensure the health and security of their communities. A number of demonstrably successful projects identified were not able to continue because the organisation had received no further funding for that project. In one case, funding was received for another project so attention had to be diverted to meet the intended outcomes of that project, rather than continue with the work already done in the previous project.

In a few cases, Aboriginal and Torres Strait Islander communities have received funding for health projects from sources other than government. One community received \$500,000 of community partnership funds from an international pharmaceutical company for health developments over a three-year period. This helped the community establish a locally-managed primary health care service that has continued to work in the suicide prevention area. In another case, in-kind support from the State/Territory lottery office was received for a road injury project.

Others involved in ongoing projects were highly committed to change, but frustrated by the lack of ongoing funding for what they considered highly worthwhile programs. The availability of funding clearly influences the momentum of a project. Most thought that not enough was being done to address the problems that confronted them. Many organisations had to supplement from their own resources funding received for projects:

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. (NT Women's Legal Service)

Often projects were able to operate by piecing together available resources:

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

In a number of cases, it was reported that no long-term funding could be accessed to implement the project in the way it could have benefited the community the most.

Cost-effectiveness of projects

Again, it should be noted that levels of funding were not recorded for each project. Participants were asked about their views of the cost-effectiveness of the programs. Without exception, participants interpreted this question as referring to the value of projects to the community in relation to the budget on which they were operating. Their responses do not provide the basis for a cost-benefit analysis, a task best undertaken by a thorough evaluation of the project.

Most informants found it difficult to determine the cost-effectiveness of projects. Some saw this as trying to put a price on people's lives:

If one person's life is saved then it is worth it. (Injury Surveillance Project)

In this sense, most participants regarded their project or program as highly cost-effective:

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. (individual comment)

and:

Very, very cost effective. It's a very good investment. In this environment it takes a long time to build relationships. (individual comment)

Sometimes the project was seen as cost-effective because of the value relative to the low resources allocated to it:

All up, the project cost \$10,000. Which was definitely good value. (individual comment)

At other times, the project was seen as good value because of cost cutting in some area:

In your opinion, was it cost effective? Absolutely. The staff are underpaid. (individual comment)

Transferability of projects

As noted previously, Shannon et al. (2001a) point out the importance of acknowledging that intervention strategies for injury surveillance and prevention projects developed and tested in one context do not necessarily work in another. Most of those interviewed for this project were of the opinion that projects developed in one community could be used in other communities, particularly in the same region. In a number of cases, the development of models was one of the intended outcomes of the project. In all cases, however, it was agreed that the local conditions within a particular community had to be taken into account.

Monitoring and evaluating the project

This project identified considerable variation in the degrees and ways in which projects are monitored and evaluated. This appears to be closely related to the requirements of the funding body. Projects funded by ATSIC — for example, Fixing Houses for Better Health — underwent evaluation using both qualitative and quantitative data as well as ongoing internal monitoring. In a number of projects, constant monitoring was integrated into the project (see for instance the PADV meta-evaluation at <http://www.padv.dpmmc.gov.au/>).

Data collection and analysis for a national evaluation of the Department of Family and Community Services (FaCS) Stronger Families and Communities Strategy has recently begun. The evaluation framework has been developed, taking into account the large number of projects funded by the strategy (800 projects) of varying sizes and different desired outcomes. All projects will be asked to complete a questionnaire, which looks at processes as well as outcomes. A smaller sample of projects in the community context will supplement the questionnaire data.

Formal evaluations provide valuable and reliable information about the impact a project is making, and there is a strong recognition of the importance of evaluating projects. It can provide excellent feedback to organisations about the work they are doing. A number of project coordinators noted that organisations are never resourced to evaluate their project work. Some organisations carry out and document, in-house evaluations (see for example, ‘Outcomes’ and ‘Evaluation’ in Case Study 11, later in this volume).

The Evaluation of the Effectiveness and Efficiency of ATSIC Family Violence Prevention Legal Service Unit (FVPLU) in Darwin Final Report (May 2001) found that the Top End Women’s Legal Service (TEWLS) Aboriginal Women’s Mobile Outreach Project was an example of innovative best practice. It was thought to be highly regarded and as providing a vital service because of its strong elements of community empowerment, community engagement and ownership. The model was seen as culturally appropriate and addressing the logistics of quality service delivery for remote communities.

Not all evaluation involves a formal process. Sometimes, informal feedback and comment can provide a good sense of what works and what does not at the local level. Sometimes it is clear when a project has had an impact. The next section will discuss the sorts of information organisations use so that they know how they are making a difference.

How do you know if the strategies are working?

All informants were asked about the success of their projects. The following responses were recorded.

Achieving a reduction in injury

In a minority of cases projects led to clear improvements in the form of a possible reduction in injury. In the case of a road safety project, for example, the results were tangible: new warning signs on the road, more lighting, and more awareness of issues. Prior to the project there had been there had been at least one injury or fatality every 6 months in the last 5 years:

They now have lights along the most dangerous stretch of road. No injuries in the last 6 months. (WA road safety project)

Similarly, one suicide prevention project achieved dramatic results in its first few years:

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. (Queensland suicide prevention project)

For others there was a general sense that a reduction in injury rates may be occurring:

At this stage, the reduction in injury has been a minor improvement, but (the service) has *definitely made a difference*. (WA men’s health project)

Some noted that they were doing the best they could with the available budget:

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 safer and healthier after the project. (National housing project)

And for some it was too early to say:

As the project was piloted in December 2002, it is too early to estimate the impact of the participants and their community to know what difference the project has made, or whether it has prevented or reduced injury. (NT sports injury project)

The feedback from others is positive

Feedback from those in the community can be a good indicator of whether or not a project is making a difference. Feedback received about projects can be from participants and stakeholders:

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 a successful program. (NT sports injury project)

Or from other different sources, such as the police, or another health service:

The 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. (WA Men’s Health Project)

People tell good and bad stories about how things are going:

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. (NT Women’s Legal Service)

People who visit from outside also provide feedback:

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 has come over twice and the coordinator came and spent a week here with us. We also get a lot of groups from unis. (NT night patrol)

The project has an observable positive effects

In the majority cases, the reduction in injury was only one of the observable benefits that resulted from the intervention (note that these are perceptions of positive effects, rather than objective conclusions based on data analysis).

There were many other indicators of success, including —

1. The general health of clients:

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. . (WA Men’s Health Project)

2. Less crime:

There is less alcohol-related street crime. (WA men’s health project)

3. Increased knowledge and understanding:

Women clients are starting to understand the cycle of violence — clients now come to the refuge at the build up of tension rather than wait until violence erupts or hide weapons from partners. (WA women’s health project)

4. Self esteem:

Women are learning they can make their own decisions, that they have support, which helps to overcome their lack of confidence and low self-esteem. These successes would not have been achieved without the Service in place. (WA women's health project)

5. Improvements in the general health of the community:

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. (WA water safety project)

6. Improvements in social life and decreased boredom:

Furthermore these programs have the potential to decrease boredom in the communities where there is limited social and recreational opportunities. (WA water safety project)

Sometimes the bringing to completion of a process can bring its own fulfilment:

[The project] provided a great opportunity to see something from just an idea develop through to an actual program run in a remote community. (NT sports injury project)

Laying the groundwork

For projects that had set out long-term injury prevention as their major goal, the immediate achievements were in making future improvements in injury rates possible through future community projects. This included the establishment of trust between the project proponents and the community, and the formation of partnerships:

An immediate outcome resulting from the project has been that communities have acknowledged the significant role 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. (NSW injury surveillance project)

and:

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 — and a school committee, made up of school members and parents, organised classroom sessions, and an interactive session focus on community hazards involving workers responsible for community safety issues. (SA school education project)

Difficulties with measurement

Despite quantifiable outcomes, the impact on rates of injury was very often hard to assess because of the complex nature of the problem being addressed, and because of the lack of thorough and long-term evaluation.

In the Fixing Houses for Better Health project, data show that of 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%. However,

It is impossible to determine, as to whether it has prevented or reduced injury. There is no base line data available. Even if this data was available, confounding factors would make it difficult. Would the results have happened anyhow? No, absolutely not. (National housing safety project)

and:

Overall there has been some effect. But family violence is so endemic that it's hard to make a difference. (WA women's health project)

Raising awareness, or getting the issue out in the open, and increasing understanding of the injury problem was an important indicator of success, but one which is difficult to measure:

One indicator of success was that family violence, sexual assault, child sexual abuse is being talked about openly largely due to this program. (NSW family violence education project)

Factors influencing success

The question of what makes a project successful is not a straightforward one. Definitions of success differ between individuals, organisations and funding bodies that may have different perspectives and objectives. Attempts to define ‘achievement’ and ‘success’ and the development of frameworks for the analysis of these factors have been discussed above (see earlier section, ‘Meta-analysis of projects’). This section describes what success means to those responsible for coordinating and managing Aboriginal and Torres Strait Islander injury projects, and the factors they identified as underscoring successful projects.

Those consulted about individual projects and overall programs provided a wide range of views on factors underlying the success of a project. The following factors were consistently mentioned as influencing the success of projects:

- adequate funding and resources;
- community control/respect for community protocols;
- community acceptability and involvement;
- partnerships;
- a functioning organisation and good project management;
- skilled and committed personnel; and
- understanding the underlying factors related to injury.

These factors are now each considered in turn.

Adequate funding and resources

As demonstrated in the discussion in the previous section ‘Funding’, projects are more likely to be successful when they have secured ongoing funding for their activities. There is a clear need for adequate ongoing funding to support projects that are demonstrating good qualitative and quantitative outcomes, and clear overall benefits for the community.

Community control/respect for community protocols

Having a steering group of stakeholders and/or having a community reference group has been identified both in the literature (e.g. Shannon, 2001b) and in the interviews as a key aspect of a successful project. The inclusion of the whole community, and not just dominant families, is clearly an ongoing challenge for many communities. This issue is discussed further in the section below ‘Factors impeding success’.

Community acceptability and involvement

Most projects stressed the importance both of the acceptability of the project to the community and their involvement in it. The following quote is typical of the sentiments often expressed about any Aboriginal and Torres Strait Islander community project:

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. (NSW injury surveillance project)

What is acceptable to an Aboriginal and Torres Strait Islander community, then, clearly depends on local needs, and not on preconceived ideas of what is culturally appropriate for Aboriginal and Torres Strait Islander people. Further, it is important to recognition of the diversity of Aboriginal and Torres Strait Islander communities

Each community decided how they wanted things to run. (NT women's legal service)

Some factors, which appear to contribute to community acceptability across the board, include good information and communication strategies, and a highly flexible approach. Information should be available and accessible in a way that fits in with the community's style, needs and priorities. It is also important to feed back the results of research or project outcomes to the community. Timelines need to be in accordance with community needs, not government or organisational deadlines as some highly successful projects recognise.

Changing the attitudes and behaviour of individual perpetrators of violence is possible through community endorsement of a project, as the following example demonstrates:

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

Very often, in order for a project to be accessible to everyone in the community, it also needs to offer some very practical assistance. On one level, the teaching of personal living skills such as parenting and relationships, and supporting people to increase their confidence and self-esteem, can provide this assistance.

At another level, some projects recognise that attention to basic issues, such as food and transport for the participants, increases the likelihood of successful outcomes:

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. (SA children's theatre project)

Access to reliable information

The collection of reliable data has been an important first step for a number of successful projects. Projects based on an injury surveillance model, for example, undertook a lengthy process of obtaining the most reliable data not only about rates and types of injury that occurred in communities but also the context in which they occurred in order to gain a good understanding of the experience and the priorities of the Aboriginal and Torres Strait Islander communities. This data gathering process, done in close consultation with members of the Aboriginal and Torres Strait Islander community, was then able to be used to develop short- and long-term strategies that are likely to be successful, acceptable and sustainable, and ultimately lead to safer Aboriginal and Torres Strait Islander communities.

Information sharing

The sharing of information can enhance the likelihood of a successful intervention and encourage good practice by: learning from the successes and mistakes of others; avoiding duplication of effort; and being able to access the best available information. A number of important recent initiatives in suicide prevention, regional injury prevention and education, based on the transmission of knowledge, have been discussed above.

Partnerships

There are a number ways that are making projects sustainable. One is the current emphasis on the establishment and maintenance of partnerships. In some cases, the development of partnerships is a key objective of the project. For example, the North Queensland Indigenous Injury Prevention Partnership's (NQIIPP) Injury Prevention in Indigenous Communities Project aims to establish, implement and evaluate more effective ways to prevent injury in Aboriginal and Torres Strait Islander communities in north Queensland, through establishing and maintaining active working partnerships among communities and stakeholder organisations. The NSW health department-funded injury surveillance projects similarly sought to establish and maintain active partnerships:

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. (NSW injury surveillance project)

and:

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. (NSW injury surveillance project)

Partnerships can be facilitated by a formal partnership agreement, such as Yarrabah community's Partnership for Health Project that integrates all primary health care services. The key stakeholders for the three-year Partnership for Health Project include Gurriny Yealamucka Health Service Aboriginal Corporation, Yarrabah Community Council, the University of Queensland and the GlaxoSmithKline pharmaceutical company. Linkages have been formed with 21 other government and non-government organisations. The implementation of the men's health programs is one of the objectives of the new Partnership for Health project. The strategies have been developed and are part of the Yarrabah Health Action Plan.

Good organisation and management

Organisations that are well organised, functioning and professional were thought by all those consulted to be more likely to produce good projects:

The neutrality of project managers, particularly in terms of family relationships within the community was an important factor in the success of a project. (Queensland family violence project)

Skills in planning, implementing and evaluating safe, effective and sustainable programs were seen to be crucial. Among other things, this means having project personnel who are able to build capacity as well as undertake more conventional project activities:

A critical feature was the creation of a debriefing session, to discuss the project, and the expression of emotion that transpired. (SA children's theatre project)

Good project management is seen as essential for a project to achieve its goals. For the Yarrabah Men's Health Group project, this has been achieved through a strategic planning workshop:

The health service has worked closely with Uni 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. (Queensland men's health project)

The success of the project often 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. (WA road safety project)

Skilled and committed personnel

It was seen by all those consulted as vital to have personnel within the community with the skills and qualifications to plan and implement a project. Aboriginal Health Workers have a particularly important role to play:

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. (NSW injury surveillance project)

and:

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. (SA children's theatre project)

Where skills are not there at the outset, community education and training are seen as crucial aspects of any project:

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 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. (NSW injury surveillance project)

Workers not only have to be skilled in project work and have the ability to relate easily with members of the community, they also need to display a high degree of professionalism, particularly when dealing with confidential issues. In most communities, the issue of confidentiality is difficult because of close family ties. Surprisingly, some projects found that they were able to deal with this issue through the employment of a non-Indigenous worker:

Having a non-Indigenous worker as well as an Indigenous worker was good. Women were able to confide in a person with no family connections in the region. (Queensland family violence project)

Factors impeding success

It should be noted that most of those people involved in projects that have been included as case studies were more likely to talk about their successes than their failures. They were generally unable to identify factors that may make those successes more difficult to achieve. The broader consultation uncovered a range of more global views about factors influencing the success of projects that address the safety of Aboriginal and Torres Strait Islander communities. These are discussed below.

Lack of funding

The issue of funding has already been discussed in detail above. Inadequate resources could either slow down the progress of a project or stop it altogether:

The 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. With decent funding they would be able to train people to deliver family violence workshops to pull together the organisations. However, there has been no ongoing funding for the project. Ongoing means long term planning and funding. (Queensland family violence project)

and:

The project has been successful, with a qualifier: the limited budget impacts on the outcomes possible to achieve. (National housing safety project)

Distance

Long distances between communities is a key factor in their ability to effect change, particularly in remote and large rural areas. This made project outcomes harder to achieve:

It's difficult to get women from the communities to come along to meetings — only one trip possible a month. (WA women's health project)

Organisational issues

Lack of organisational coherence, dominance of some families within key community organisations and personnel problems were all issues identified by the minority of informants for this study who were willing to share experiences of unsuccessful projects frankly (on the understanding that the project name would not be disclosed).

One of the most difficult problems encountered was that dominant families in the community received favoured treatment, making it difficult for projects to go ahead in the way planned and understood by funding bodies:

X was selective about who they invited to be involved in the project (invited family members)

Other personnel problems encountered included poor selection of personnel, lack of skill in personnel employed and lack of commitment from personnel employed:

He didn't want to do the job. Was there for the car and the money ... didn't pass on information about the project. (individual comment)

Some of the skills identified as necessary in Aboriginal and Torres Strait Islander safety promotion and injury prevention work were community development skills and, particularly in family violence work, an understanding of gender inequalities. When these were not present, the project suffered.

Problems with multiple projects in one community

Another problem identified was the large number of projects operating in communities at any one time. This could lead to competing interests, and inhibited the communities' ability to work coherently towards addressing their problems. One informant noted that it was no longer possible to get people to come to a community meeting:

Specific purpose groups in the community have led to some problems. You can't get a community meeting. People are in different interest groups. There is competition. There are different layers of coordination. (individual comment)

Inability of projects to deal with the core issues

The view of many project workers is that the core issues of Aboriginal and Torres Strait Islander health and safety are not being addressed. They are only doing 'bandaid' work. The sheer scale of the problems of injury encountered in many Aboriginal and Torres Strait Islander communities made it difficult for project workers to see any improvement in the future. A grim picture of Cape York communities — already noted in studies such as the Cape York Communities Injury Study (Gladman et al., 1997), the Cape York Justice Study (Fitzgerald, 2001), and the Women's Taskforce Report (Queensland Government, 1999) — was echoed in remarks made by a number of informants in this project about the factors which have been identified in many studies as the underlying determinants of health —

1. Environment:

There is one environmental health officer for (a vast area). Nothing in place and no way to enforce recommendations and reports. Total hopelessness for Indigenous communities. (individual comment)

2. Food:

Prices are triple to quadruple. Huge monopolies of shipping companies — won't do anything unless it's paid for. Communities have no control over shops — no power to be involved in any processes. (individual comment)

3. Education of children:

The system has let down the children — Anyone who makes it to the workforce borders on a miracle. (individual comment)

4. Employment:

Hardly anyone managing to keep full-time job — only work CDEP — absolute failure — dehumanising — people need commitment, skills training and permanent work and ownership as well. (individual comment)

5. Housing:

Concept of housing commission, some families have better homes — others disgusting — every politician should be sent up there — poverty and squalor. The more you look, there are more issues. (individual comment)

6. No community involvement in political process:

Political process needs altering. Indigenous groups disenfranchised. Can't form collective bodies. (individual comment)

The informant here referred to an inability of Aboriginal and Torres Strait Islander people in remote communities to engage in any meaningful democratic or decision-making process, at any level, because of the fragmentation of their lives as a result of the factors above, and the resultant epidemic of abuse and violence.

Lack of commitment to change from government and service organisations

Some of those consulted criticised government and other bodies as lacking a true commitment to change in Aboriginal and Torres Strait Islander communities. Retention and commitment of staff were seen as important factors:

It is important to get the services committed to change — e.g. managers of regional group were asked to delegate someone in their office to be advocate in their services for domestic violence. This didn't always happen. One issue was a change in personnel in departments, also a lack of commitment from senior people in organisations. (Queensland family violence project)

Conclusion: Key issues emerging from the consultations

Injury is a complex health problem. Unlike many other areas of health, it is not easy to demarcate injury clearly as a health issue. The prevention of injury is similarly complex. The consultation phase of the Aboriginal and Torres Strait Islander Injury Prevention Activity Project involved a broad search to identify all current relevant projects and programs targeting Aboriginal and Torres Strait Islander communities that would have the effect of reducing or preventing injury. A further qualitative investigation of the experience of some of those involved in programs and projects provided the basis for the analysis of factors influencing the success of projects in this field.

The consultation was focused on people and organisations involved in funding, developing and coordinating Aboriginal and Torres Strait Islander injury prevention projects, and included funding bodies, researchers, community educators, community workers, managers and project coordinators. It did not include consulting the 'users' or 'consumers', of projects — that is, the Aboriginal and Torres Strait Islander target population. This valuable information would normally be part of the ongoing evaluation of any individual project or program.

The Aboriginal and Torres Strait Islander Injury Prevention Activity Project identified a large number of current, recent or planned activities, which may have an impact on reducing the high rates of injury prevalent in Aboriginal and Torres Strait Islander communities. Relatively few of these specifically set out to reduce or prevent injury, and a large proportion focused on one of a few external or contributing causes, notably alcohol and family violence.

Most of these projects were located in rural or remote locations, were strongly community-oriented and operated on short-term budgets. As well as urban Aboriginal and Torres Strait Islander people, other neglected groups, who have been identified as vulnerable groups at risk of injury, included the elderly, children, the disabled and those with serious mental problems.

The review identified many successful innovative and creative projects using a variety of strategies to address injury issues. Projects were more likely to be successful if they had a high degree of community involvement and acceptability, involved partnerships, were run by functioning organisations with trained personnel, had a good understanding of the factors underlying the types of injury problems being addressed, and were adequately funded.

Factors impeding success included distance, a lack of organisational coherence and a lack of funding security. Government directly or indirectly funds the vast majority of the projects identified. The inadequacy and short-term nature of funding is a serious problem for many community-based projects.

Few projects included here, however, address the underlying economic marginalisation faced by most Aboriginal and Torres Strait Islander people, particularly in rural and remote areas where opportunities for employment and education are extremely limited, even though the need to address such underlying issues is widely recognised as being fundamental to improvements in all other areas of health and safety. Clearly, a whole-of-government approach is necessary to address all of these areas.

A key area of concern among Aboriginal and Torres Strait Islander community workers is the lack of a coordinated approach, frequently evidenced when numerous government agencies and organisations are involved in multiple projects within communities. In light of this, the recommendation for the development and funding of action plans seems a sensible one.

The project revealed few good evaluative studies. Evaluations provide valuable and reliable information about the impact a project is making, and there is a strong recognition of the importance of evaluating projects. A number of project coordinators noted that organisations are rarely resourced to evaluate their project work.

The value of sharing information should not be underestimated. The mapping of information on the basis of current activity, organisations involved, successes and failures, and planned projects is important information of benefit to organisations, funding bodies and policy makers. The establishment of a communication, information-sharing and collaborative network among individuals and organisations has been identified as a crucial factor in the ongoing success of a project.

Aboriginal and Torres Strait Islander communities are highly sensitive to issues around consultation and community involvement in decision-making. It is imperative that these factors be taken into consideration in any activity designed to reduce the incidence of injury in their communities. Aboriginal and Torres Strait Islander people are also weary of the lip service paid by governments to consultation. Numerous reports and recommendations emphasise the importance of community control, community acceptability and ongoing community involvement as key factors in any Aboriginal and Torres Strait Islander community project.

At the same time, many projects fail because of problems at the local organisational level discussed in the previous section. The solution is not to abandon a commitment to community involvement, but rather to assist communities to develop further. This can be achieved by: supporting communication and organisational infrastructure at the community level necessary for project success; supporting existing work where achievements are being made; and recognising and addressing the issues of environment, nutrition, education, employment and housing underlying all aspects of the health and wellbeing of Aboriginal and Torres Strait Islander communities.

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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	Rosly 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 work 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 (TEWLS) 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 of 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 "trotto 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 addition, 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 ATSIIC — 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 ATSIIC 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 banded 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 led 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 from 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 km² 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 than 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 February 2003

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 from 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 and 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 Yirkala 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 Yirkala 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 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] [Kurna] [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 be 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 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 set 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.