

Community-based Indigenous Injury Prevention Projects

Kathie Clapham



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Dr Clapham is an Aboriginal Australian with over 10 years experience teaching and researching Indigenous health and education. She has a PhD in Anthropology and academic and research interests in injury prevention; developing the Indigenous health workforce; race and health inequalities. Kathleen currently works as a Senior Research Fellow in the Injury Prevention and Trauma Care Division of The George Institute for International Health. Prior to this she held the position of Senior Lecturer and Head of School, Yooroang Garang: School of Indigenous Health Studies at the University of Sydney. Kathleen is an executive member of the Australian Injury Prevention Network (AIPN) and holds the position of Indigenous Liaison Officer. Her current research focuses on Aboriginal health workers and injury prevention in NSW and the development of injury prevention and safety promotion interventions for Aboriginal children and youth.

Researching the role of Aboriginal Health Workers in preventing injury in urban NSW

Injury and its prevention is a fairly new issue on the Aboriginal health agenda. Injuries tend to be hidden among the wider health and social concerns confronting Aboriginal and Torres Strait Islander people. But recent studies have shown that Aboriginal and Torres Strait Islander communities suffer nearly 3 times the rate of fatal injuries than the general community and injury from interpersonal violence and poisoning are up to 10 times more frequent. Public health, including evidence-based research, interventions and evaluation, have a crucial role to play in preventing injuries in Aboriginal communities.

Two recently published reports¹⁻² identified almost 300 prevention and intervention projects and programs in Aboriginal and Torres Strait Islander communities that were relevant to injury and safety. Projects were selected using broad criteria in order to identify, as widely as possible, initiatives, projects and programs that would improve the safety and reduce the likelihood of injury amongst Indigenous people. Interestingly, fewer than 40 of the projects/programs identified themselves as 'injury prevention' projects. The vast majority were local, under-resourced, community-based projects, conducted by Indigenous organizations, to prevent violence, deal

with alcohol abuse, improve community safety through night patrols or, taking a longer term approach, aimed at early intervention, building capacity, or improving the social and emotional well-being of individuals and the community.

Many of the public health initiatives undertaken in Aboriginal health and community settings are based on the local knowledge and expertise of Aboriginal health workers. Over the past few years, I have been undertaking research on injury and its prevention in Aboriginal communities in NSW. Two unique features of this research are, firstly, that it draws attention to the role that Aboriginal health workers play in responding to injury in Aboriginal communities, and raises the potential role of health workers in injury prevention. Secondly, it focuses on urban Aboriginal communities, where the majority (66%) of Australia's Indigenous population lives.

Aboriginal Health Workers perform a unique role within the Australian health care system. They are a group of health practitioners who work within a broad primary health care and community development framework. They integrate western and traditional approaches to health and are often seen, and see themselves, as providing a 'cultural bridge' between two traditions. To work effectively for the health of their communities, Aboriginal health workers need an

Continued on page 2

In this issue ...

- 1 Community-based Indigenous Injury Prevention Projects.
- 3 SIPP Communique
- 5 Injury on the Internet
- 5 Did you know...
- 5 New on the RCIS Website
- 6 Conference update, AIPN
- 7 Violence - Make a Difference
- 8 NSW Adopts Aboriginal Safety Strategy
- 9 Information about Injury in Indigenous People
- 10 Collecting Patient Registration Information Training Program
- 13 From the Coroner
- 14 Something to read?
- 15 Diary
- 16 References

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Continued from page 1

understanding that comes not just from the traditional western sciences, but also from a firm understanding of Aboriginal ways of understanding health. Aboriginal health workers are key personnel for health improvements. One of the major objectives of their positions is to improve Indigenous access to mainstream health services. By providing cultural awareness and training to the health professionals they work alongside, Aboriginal health workers are also charged with explaining the way in which historical, social, political and economic factors have impacted on, and continue to impact on, the health of Aboriginal communities. Aboriginal health workers provide culturally sensitive and specific health care with regard to the values and traditions of the individuals, families and communities they serve.

Despite this positive role, the closeness to the individual health and social problems and the taxing demands of the Aboriginal communities in which they work and live and the ongoing lack of resources for their work are some reasons given for the high levels of stress and burnout which Aboriginal health workers experience³. Although there have been some improvement in education and training opportunities, the industrial position of Aboriginal health workers has improved little; they still occupy the lower end of health occupation pay scales. Aboriginal health workers have little professional recognition amongst other health professionals and are often caught between the demands of the health service which employ them and the needs of their communities.

Over the past year I have been undertaking research with Aboriginal health workers working in South Western Sydney, a large sprawling suburban area on Sydney's fringes encompassing the cities of Campbelltown, Liverpool, Fairfield and Bankstown. Qualitative data was collected through a series of in-depth face-to-face interviews and focus groups with Indigenous health workers working in community health and hospital liaison. Interviewees were asked about the kinds

of injuries seen in everyday work; factors contributing to injuries; the impact of injuries on the local Aboriginal community, on the health workers; the degree to which Aboriginal people are concerned about injury; what should be done to address these problems; who should be involved; the role of health workers in preventing injuries; current levels of skills and resources to take on injury prevention. I am currently writing up the results of this research, but I have highlighted below some of the preliminary findings.

Most of the Aboriginal health workers I interviewed had thought little about injury as a health issue. Until recently there has been little awareness of the impact of injury on Aboriginal people. Health workers, therefore, tend to concentrate their efforts on illness, such as diabetes or heart disease, or on issues such as drug and alcohol or mental health. Interviews confirmed that fear and previous bad experiences continue to prevent many Indigenous people in urban areas from accessing mainstream health services. This means that minor conditions, including injuries, very often remain untreated. Interviewees suggested that, for Aboriginal clients, health is often not a priority until there is a crisis. Practical aspects of life such as putting food on the table, paying bills, supporting family members, usually take precedence. Some of the major injury concerns mentioned were domestic violence; inter-personal violence outside the home; road safety issues such as child pedestrian safety and the use of restraints and elder pedestrian safety; injury arising from poor housing and environments; and drug and alcohol related issues.

The health workers interviewed acknowledged the importance of injury and safety for their communities. They routinely work across sectors to solve the complex health and social problems that may confront them on a daily basis. They are well placed to expand the injury prevention and safety promotion agenda. However, Aboriginal health workers have limited access to resources

to make significant changes, and require well supported and ongoing training and education opportunities. In addition to general qualifications as health workers, there is clearly a need for specific training in injury prevention and safety promotion across a wide range of areas.

More recently I have been focusing attention on the impact of injury on urban Indigenous children and youth. A proposed study will investigate the impact of injury on Indigenous children and youth (aged 0-14 years) in South Western Sydney. The aims of the study are, firstly, to document the extent of injury in this population group; secondly, to increase our understanding of suitable injury prevention strategies for this population; and thirdly, to propose community based collaborative local interventions, which will reduce injury among urban Indigenous children and youth, and promote the safety and resilience of Indigenous children and youth living in urban environments.

There is clearly a need to establish a sustained long-term focus on Aboriginal and Torres Strait Islander injury prevention and safety promotion. Recent policy initiatives such as the NSW Aboriginal Safety Promotion Strategy have helped to raise awareness of injury and its impact on Aboriginal communities and to provide opportunities for communities to participate in defining their own solutions. There is clearly scope for more research to be undertaken with Aboriginal people in injury prevention. As the NHMRC Roadmap for Indigenous health research⁴ emphasises, there is an urgent need for strategic research that benefits Indigenous people through improved health outcomes as well as greater participation of Indigenous people in research.

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Communique

2-3 March 2004

The 11th Meeting of the *Strategic Injury Prevention Partnership* was held in Sydney on 3-4 March 2004. Members attending the meeting were Rod McClure (Co-Chair), James Harrison (AIHW), Bruce Wight (Commonwealth), Richard Franklin (AIPN), Pam Albany (NSW), Michael Tilse (QLD), Ingrid Coote (ACT), Nicola Rabot (Victoria), Stan Bordeaux (TAS), Sandy Brinson (NZ). Keith McLea (NZ) and John Wunsch (Consumer Safety Unit, Treasury) attended the first day, and Rebecca Mitchell (NSW) attended for some of the first and all of the second day. Also in attendance were Annamaree Reisch and Samantha Diplock (SIPP Secretariat).

Apologies were received from John Scott (Co-Chair), Ron Somers (SA) and Nicole Bennett (WA).

Updates from jurisdictions

Members provided updates on their recent work.

Australian Capital Territory

Ingrid Coote confirmed distribution of the ACT Water Safety Campaign posters and brochures to all school children and to public pools. The commencement of a prevention program targeting falls amongst the well elderly, the Community Outreach Assessment Pilot was announced. An educational resource kit aimed at reducing accidental injury in children had been distributed to regional primary schools in February. The kits comprise of an interactive CD-ROM containing activities based on a range of safety messages, and has been produced by the Snowy Hydro SouthCare Rescue Service.

South Australia

There is an upcoming coroners case involving a bath seat. Tightening requirements to leash dogs in public places progresses. It was noted that the Trauma Register has been invaluable as an outcome measure. Other items were severity scoring of diagnosis codes in hospital data, and broadening work on CATI modules eg. Coroner Information System. ICD-10 – suggestions to be sought from SIPP.

New South Wales

Pam Albany extended an invitation to all SIPP members to attend the upcoming Injury Prevention Network Meeting, scheduled for 3-4 May, 2004. The Aboriginal Safety Plan, a management tool for identifying and managing risk is progressing. The NSW Fall is to be released at the beginning of April.

Queensland

Michael Tilse gave information on the Joint Child Injury Project with Emergency Services in Mt Isa and Mackay. He also reported that the Falls Network meeting is working well, and has contributed to information sharing.

Victoria

Nicola Rabot talked about the SafeStart injury prevention program (for 0-8 years) which started 18 months ago. A program evaluation is due in June 2004. Nicola reported that the second round of injury prevention research grants currently being assessed. New strategy is to be developed in the near future.

Tasmania

Several items were tabled by Stan Bordeaux:

- Justice Department reviewing product safety legislation.
- North west coast Womens Health Unit has engaged trained fitness instructors to provide exercise for older women.
- Some funds obtained from gambling taxes on poker machines (to be used for community project use) have been directed to injury prevention in children.
- Report on child injury prevention in the home currently being prepared.
- Attempts being made to have injury prevention recognised and links established with 'health lifestyles' (eg. through nutrition and physical education programs).

New Zealand

Sandy Brinson and Keith McLea reported that the Injury Prevention Network

is growing and connecting at government level. Ways for injury prevention to link in with nutrition etc are being explored.

AIPN

From Richard Franklin, news about upcoming conferences and courses:

- Injury Prevention and Safe Communities Conference–15-17 September 2004 (Mackay).
- Safe Communities workshop to be held immediately before Conference.
- Injury Prevention short course to be held 12 & 13 September 2004.

Australian Government (Department of Treasury)

- The Parliamentary Secretary to the Treasurer, the Hon Ross Cameron MP, recently launched awareness campaigns for blind & curtain cord strangulation, and Fire Safety at Home.
- Brochures, booklets and web material are currently being developed for a vehicle jack safety campaign. Media activity is expected to occur in April.

Australian Government (Department of Health and Ageing)

- Report 'Projected costs of fall related injury to older persons due to demographic change in Australia' published and made publicly available.
- Updated literature review for falls prevention to be available soon on the Department's website.

Presentation on New Zealand Injury Prevention Strategy

Dr Keith McLea (assisted by Sandy Brinson) presented on the development and implementation of the New Zealand Injury Prevention Strategy. Copies of the Strategy and accompanying Implementation Plan were distributed. These can be accessed on the New Zealand Injury Prevention Strategy website at www.nzips.govt.nz

Continued on page 4

Communique

2-3 March 2004

SIPP Information for use by Australian Coroners

Members were advised that the next Coroners Meeting has been scheduled for 20 September 2004 in Darwin. A presentation focussing on linkages between SIPP and Australian Coroners has been prepared for this meeting, and will be delivered by a SIPP member.

Standards/Legislative Clearing House

Members are consulting with their jurisdictions to explore the feasibility of funding a standards/legislative clearing house project, on a trial basis, for a period of one year. The project would perform three functions:

1. International Standards and Legislative Clearing House
2. Action Bulletin
3. Australian Child Injury Prevention Legislation and Standards database.

Presentation on Evaluation of National Injury Prevention Plan

Representatives from the Centre for Accident Research and Road Safety–Queensland (CARRS-Q) presented an overview of the proposed methodology for evaluating the National Injury Prevention Plan. The methodology involves two components: a critical analysis of extant documents, and a modified Delphi survey. The evaluation is expected to take 22 weeks. Four groups of stakeholders were identified as key participants in the evaluation process: senior policy advisors, practitioners, researchers, and other sectors and broad community members.

Demonstration of ED Surveillance Capacity

David Muscatello provided a presentation on the NSW Biosurveillance Program, which has been funded as part of a 5 year program to enhance health disaster preparedness. This program is in development with trials currently being undertaken in 8 NSW hospitals. The presentation generated discussion regarding the collection of meaningful and timely injury data in hospital emergency departments and the challenges associated with the public health response. This

program, if deemed successful will eventually be made available to other states.

Next National Injury Prevention Plan

A summary of the outcomes of the SIPP sub-committee (formed to develop the next National Injury Prevention Plan) meeting on 3 March 2004 was provided. The sub-committee is currently exploring the possibility of having a new Plan comprised of two parts. It has been suggested that this could involve a 6-10 year injury prevention plan, and a SIPP Implementation/Progress report to be published approximately every 2 years. It is expected that a decision regarding the structure of the new plan will be made within the next few months.

Child Poisoning Prevention Project

A sub-committee has been established between the Department of Health and Ageing and the Therapeutic Goods Administration. Ron Somers will represent injury prevention issues on this committee, with a representative from the Department of Health and Ageing to also attend.

Falls Managers Meeting

The Falls Prevention Managers Meeting was held on 1-2 March 2004. A National Falls Prevention for Older People Plan is currently being developed, and is expected to be finalised by June 2004. SIPP members will review the plan and endorse it if appropriate. Following this process, the Plan will be progressed through the National Public Health Partnership (NPHP).

ATSIPAC Update

A broad structure for the Aboriginal and Torres Strait Islander Injury Prevention Advisory Council (ATSIPAC) safety plan (to be incorporated into the new National Injury Prevention Plan) has been developed, with the plan expected to be finalised by August 2004.

Copies of the publications 'Injury Prevention Activity among Aboriginal and Torres Strait Island Peoples Volume I: Current Status and Future Directions'

and 'Injury Prevention Activity among Aboriginal and Torres Strait Island Peoples Volume II: Programs, Projects and Actions' are expected to be available on the Department of Health and Ageing's website in the near future.

Pool Fencing

Changes to the Australian standard for pool fencing are currently under consideration. Option C is likely to be removed, meaning that 4 sided pool fences will be required. SIPP members agreed that this proposal should be supported. A paper is expected to be available for comment in March/April 2004. A new water safety plan is being developed, and is currently being considered by the Australian Water Safety Council.

Future Meetings

SIPP has a teleconference scheduled for 25 May 2004.

The next face to face meeting is to be held in Mackay on 14-15 September 2004.

Injury on the Internet

Indigenous Australia

Operating out of Edith Cowan University, Perth, the Australian Indigenous HealthinfoNet is a valuable source of peer-reviewed information on the many areas that affect the health of Indigenous people. Topics include health (including injury), population, social, cultural, economic, historical and physical environment issues. The site is well presented and specific interest areas are easy to locate.

Of particular note is the "Summary of Indigenous Health", which provides an excellent overview of the Indigenous population, births and pregnancy outcome, mortality, hospitalisation and selected health conditions. Each topic has a menu to select from. Health expenditure, endnotes and references are also posted. The Summary is frequently updated to provide the latest, most

accurate, available information, with month of update listed at its head.

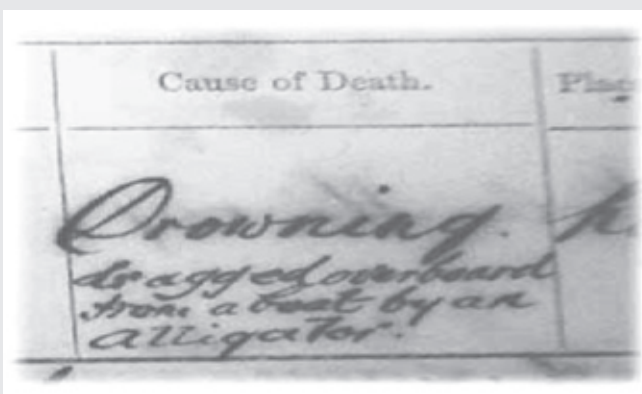
Other choices from the navigation menu are *Programs and related health services*, *Links* to related sites, and an *e-journal*. The *Resources* selection comprises a bibliography, health topic reviews, ethics considerations, research matters, and medical and technical glossaries. The *Our services* selection includes a noticeboard, listserve, media page, courses available and upcoming conferences.

The address for this site is:
<http://healthinonet.ecu.edu.au>



Artist unknown: *Wandjina Figure*. Ochre, clay and gum on bark. The Edith Cowan University Art Collection.

Did you know...



The first death registered in the Northern Territory was due to an external cause. William Read was dragged from a boat by an 'alligator' (crocodile) in December of 1870, and subsequently drowned in the Roper River.

The death was registered in March, 1871. Above is an extract from the original certificate. View the full certificate on the Northern Territory Births, Deaths and Marriages website: www.nt.gov.au/justice/graphpages/bdm/index.shtml

New on the RCIS Website

- Clare Bradley, James Harrison (RCIS), Injury risk factors, attitudes and awareness: a submission to the CATI-TRG
- Shaun Stevenson, John Langley (University of Otago, NZ), Geoff Henley, James Harrison (RCIS), Diagnosis-based injury severity scaling.
- Tim Driscoll (ELMATOM Ltd, NSW), Geoff Henley, James Harrison (RCIS), The National Coroners' Information System as an information tool for injury surveillance.



Conference Update

The following information is drawn from the conference brochure.

Preparations for the 7th Australian Injury Prevention Conference and the 2nd Pacific Rim Safe Communities Conference are progressing well, with an exciting draft program already in place. The conference coincides with the designation of the Mackay Whitsunday Safe Communities (established in February 2000) as a WHO Safe Community. The conference will attract members of safe communities, injury prevention researchers, practitioners, policy makers and advocates from Australasia and the Indo Asia Pacific regions.

Associate Professor Jim Nixon (University of Queensland) is Chair of the Scientific Committee; "Over three days, we will explore the theme *Safe Living on the Edge* using a combination of plenary sessions, concurrent sessions, workshops and forums. We have engaged some excellent keynote speakers and drafted what should be an interesting and enjoyable program."

Four keynote speakers offer aspects on injury management from the community perspective.

Paul Kells (Order of Ontario, Meritorious Service Medal) comes from Canada, and is committed to the concept of Safe Communities and to educating young people in workplace safety. His commitment is motivated by the loss of a son in a workplace accident.

David Sleet (PhD FAAHB) has worked in Western Australia in road accident prevention research, and in injury control for the Health Department of that state. He is currently with the CDC, where he has been responsible for developing the focus on public health. He has been involved with systematic reviews of community-based interventions to reduce motor

vehicle injuries, and has also worked on the road safety project for World Health Day 2004.

Rob Lee (PhD) gained his doctorate in psychology in Scotland, and worked for the Royal Australian Air Force (RAAF) as a human factors specialist, breaking ground in air accident investigation in Australia. Dr Lee is now an international consultant for the aviation and other high technology industries, in the areas of human factors and systems safety.

Dr Carolyn Coggan heads the Injury Prevention Research Centre (IPRC) at the University of Auckland, where she is an Associate Professor. The Centre is affiliated with the WHO Collaborating Centre on Safe Community Safety Promotion. Professor Coggan's key interests in research and evaluation are prevention of injury from violence and suicide. She has been instrumental in the development of the New Zealand Injury Prevention Strategy.

The scientific program will explore the theme *Safe Living on the Edge*, incorporating addresses from the keynote speakers, plenary and concurrent sessions, workshops and forums. The conference theme will be examined in four threads: Managing Risk (researching the unknown, attempting the new); Change (how to do it, who to target); Society (equity, marginalised groups); The Pacific Rim (issues specific to this area).

The full conference brochure details a satellite Community Safety workshop, and also a short course in Injury Prevention.

The general program will include papers from contributors on:

- safety and injury prevention in aviation
- children
- indigenous populations
- workplaces in particular the construction industry

- farms
- homes
- communities
- on the road.

In addition to the main themes of *Safe Living on the Edge* the program will include sessions preventing injuries at home at work and on the roads.

With rainforests, mountain gorges, lush hinterlands, estuarine streams, white beaches and the Great Barrier Reef there is a lot to love in the Mackay Whitsunday Region.

A coastal city with sandy beaches and tropical islands, Mackay combines country hospitality with all the attractions and commercial facilities expected of a large regional city.

Whether you enjoy cultural pursuits, nature based activities, sailing, diving or simply relaxing, there are many things waiting for you to discover.

For holiday information visit:

<http://mackayregion.com>

<http://whitsundaytourism.com>

The Conference is being organised by the Australian Injury Prevention Network.

Full details of conference registration, workshops, social activities, travel and accommodation are available on the website <http://aipn.com.au>



Violence - Make a Difference

by Deborah Cutting

Intentional injuries have emerged as a growing issue in Western Australia, particularly for males, young people, Indigenous people and rural residents. The Department of Health's recently released "Injury in Western Australia: An Epidemiology of Injury 1989-2000," ranks self inflicted injuries as the most common cause of injury death in ages 25-59 years and demonstrates that the rate of hospitalisation for injuries inflicted by another increased by 43% between 1989 and 2000.

To address the growing violence problem, the Department for Health's, Injury Prevention Branch and the Department for Community Development's, Family & Domestic Violence Unit partnered on November 25, 2003 for the 'Making a Difference' Conference. The purpose for this partnership was to explore roles and reduce duplication of efforts in violence prevention, share resources and identify ways to link and add value to the work already being done.

Dr Donna Cross, Director of the WA Centre for Health Promotion Research, presented the World Health Organisation's World Report on Violence and Health.

Participants were provided the opportunity to explore recommendations from the report and discuss the strategies and recommendations most relevant to Western Australia. To further partnerships and a commitment to action, a panel of experts, policy makers and researchers from organisations currently addressing violence was convened to advance violence prevention work.

Research on Men's Perpetrators Programs and Intimate Partner Homicide and its Relationship to Domestic Violence was also presented.

Department of Health's Manager Injury Prevention Branch, Nicole Bennett said the conference provided an excellent grounding for future collaborative projects in injury prevention. "The conference was highly successful in facilitating partnerships, expanding and strengthening violence prevention networks and increasing knowledge and information sharing for violence prevention," Ms Bennett said. "Agencies are keen to work together in a coordinated and integrated approach to address the violence problem in Western Australia," she added.



Hazel Hodgkins, Marissa Broderick, Vicki Kelly, Nicole Bennett, Cathy Campbell, Deb Cutting, Linda Villiers, Linda Parsons, Kay Lunt, Irene Stainton, Lisa Dungworth

NSW Adopts Aboriginal Safety Strategy

Pam Albany

Injury Prevention Policy Branch
NSW Health Department

The NSW Aboriginal Safety Promotion Strategy emerged from some earlier work done by NISU and local Aboriginal Communities at Cape York⁵ in 1996/7. The study identified methodologies for identifying risk environments and behaviours, which impacted on trauma outcomes in the Aboriginal communities studied. Once the reason for the trauma is identified, solutions for local action can be proposed. The most important factor in the study at Cape York was that the communities themselves collected the data, and interpreted the results through the report.

NSW Health decided to replicate, or modify this study methodology in a range of communities. Studies were undertaken in Bourke, the Mid North Coast area, the Shoalhaven area and the Blacktown region in Western Sydney.⁶ All of these studies were negotiated with, and to a greater extent conducted by, the members of the communities in which they occurred. All recommendations emanating from the studies were provided by the community members. Mr Jerry Moller of new Directions in Health and Safety provided a consultancy service to the projects.

Unlike most other public health problems, historically the causes of injury events have been viewed as a personal behavioural problem. Yet there is significant evidence in the literature and from the pilot studies to suggest that injury events are usually the result of a culmination of systemic design, maintenance and community management problems which are in turn exacerbated by intrinsic factors such as physiological deterioration, developmental incompetence, stress, relationship failure and mismanagement of addictive substances. It is impossible to manage injury patterns in the community without an understanding of the way in which risk factors confluence to produce the event. Most of the time the causes of injury are externally driven environmental factors. This is particularly true in Aboriginal communities where the provision and maintenance of community services, taken for granted in non-Aboriginal communities, are sometimes absent.

For instance, teenage boys were



Pam Albany, Manager, Injury Prevention Policy Branch, NSW Health Department

experiencing significant injuries to the lower leg whilst playing football on grounds that had not been levelled for a long time and were full of pot holes. Cut glass injury was caused by broken glass created when there was insufficient rubbish removal. Loss of safe access to public transport was caused by poor planning, and children were hurt in stormwater drains that had no covers to prevent their access.

We learned that Aboriginal people on the whole wait longer in emergency departments for treatment of more severe injury than do non-Aboriginal people. Aboriginal people are frequently suspicious of mainstream health services and will often delay treatment until the injury can be managed by an Aboriginal Health Service or until they self heal. It is possible to speculate that the reason for this distrust of mainstream services relates to a fear that they will be treated differently to non-Aboriginal patients.

It is clear that injury patterns in Aboriginal communities are different depending on the environment, the nature of the community and its relations with government service providers. There will be no "one size fits all" solution to problem solving in Aboriginal communities. That being the case, the task of developing a statewide safety strategy for use by Aboriginal communities means that

you can't develop a document which purports to tell the community what to do. Communities need a capacity to identify risk environments and behaviours for themselves and to determine a suitable local response.

Developing a statewide plan for safety in Aboriginal communities turned out to be an extremely interesting process. The process engaged a range of communities and also the groups who manage Aboriginal Health concerns. We had a steering committee who instructed us on the various "rounds" of consultation required and supported its adoption through the range of committees required.

The NSW Aboriginal Safety Strategy provides for mechanisms to identify and manage risk environments, for developing and implementing local action plans, informational and communication opportunities and for training and development.

The Program also provides for partnership development between Aboriginal communities, NSW Health and other service providers such as departments of housing, local governments, Roads and Traffic Authority, police etc. A key issue for communities will be developing the capacity to identify the ownership and management of injury risk in any one environment and to work in partnership with those authorities to reduce the risk.

The title "Aboriginal Safety Strategy" is deliberate. During the consultations it was clear that Aboriginal people did not relate to the word "injury". The concept of "safety" was popular because the word remains value free, unlike terms such as "drug and alcohol", "violence prevention" etc. The strategy has adopted two underlying principles: The right to be safe and the responsibility to promote and maintain the safety of others. It is possible that this methodology could be utilised in the development of a national plan for safety in Aboriginal communities. It is no accident that New South Wales Health is now receiving significant support from a wide range of communities around NSW. Developing and maintaining support from other government agencies will be more difficult.

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Information about Injury in Indigenous People

Fadwa Al Yaman

Dr Al Yaman is the Head of the Aboriginal and Torres Strait Islander Health and Welfare Unit at the Australian Institute of Health and Welfare. She graduated with a PhD from the John Curtin School of Medical Research at the ANU and has followed a career in teaching and researching in immunology in Jordan, the USA and Papua New Guinea. With the PNG Institute of Medical Research she was responsible for establishing the laboratories and field procedures for the first trial of a blood stage malaria vaccine for children. In 1999 she studied for a Masters of Population Studies at the ANU and joined the Institute in 2000. A major focus of the Aboriginal and Torres Strait Islander Health and Welfare Unit is the improvement of the quality of data, especially the identification of Indigenous people, in the mortality, hospitalization, and point-of-service data collections, and using statistical modelling and indirect estimation techniques with the purpose of answering the question, is the health and welfare of Indigenous people in Australia improving?

Indigenous Australians have lower life expectancies, greater morbidity and mortality and higher unemployment and imprisonment rates, than non-Indigenous Australians.⁷ Over the last 40 years, although mortality from infectious diseases, infant mortality and perinatal mortality has declined, mortality from chronic non-communicable diseases and accidents and injury has increased significantly. Injury is a relatively greater cause of sickness and death of Indigenous than other causes. Injury is the second most common cause of death in Indigenous people. Injury is closely related to other health and social issues, particularly the use of alcohol, socio-economic status and isolation.

The major categories of injury-related death in Indigenous people fall into two groups: non-intentional injury and intentional injury. Over the period 2000–2002, non-intentional injury deaths caused by transport accidents, drowning and poisoning occurred at 2.7, 3.3 and 1.7 times the rate in the non-Indigenous population. Intentional or non-accidental injury rates (suicide and assault) are almost 4 times higher for Indigenous people compared to non-Indigenous people, but the age distribution of deaths from suicide in the two populations is markedly different; Indigenous suicides occur among young people at much higher rates than they do in the non-Indigenous population. Mortality from interpersonal violence occurs at rates 9 times higher in the Indigenous population than in the non-Indigenous population and is particularly high in young adults. Indigenous morbidity rates from injury, estimated from hospitalisations, are twice the rate of the non-Indigenous population.⁷

Good information is essential for improved public health. The National Public Health Information Development Plan contains a framework that sets out the type of information that is required for improved public health. Each of these purposes requires particular sorts

of information from particular sources. Information is required about the sorts of injuries being suffered and changes in their relative frequency over time. Knowing how and why the injuries occur is important for the design of interventions. Whether and which interventions work to reduce injury is important to know. Finally, the effectiveness of the implementation of interventions must be monitored. These different sorts of information rely on different sources. Some will come from death certificates and hospitalisation data; some from coronial reports, different surveys, evaluation studies, socio-economic research and properly conducted trials.

National level information sources cover not just the Indigenous population and the identification of Indigenous people within the larger population has been problematic. If Indigenous status is not identified, it does not matter how good the quality of data or its scope is. While there has been an improvement in the identification of Indigenous status in data collected from some jurisdictions, others with large Indigenous populations are still considered to be unusable. Then the known propensity for Indigenous people to change their Indigenous status from census to census raises questions about the base population that is used to calculate injury rates for the Indigenous population.

The mortality data published annually by the ABS is based on death registrations and provides information on causes of death and is of an adequate quality for some States and Territories (namely Western Australia, South Australia, Northern Territory and Queensland). Age standardised rates based on the mortality data is similarly, reliable only for these jurisdictions. The mortality data depends on information provided by coroners, medical practitioners (who certify most deaths), and relatives and friends. Improvement of the mortality data will require changes in the way these

people provide information and report it, which is likely to be slow to achieve especially in urban areas.

Coronial reports are carried out for almost all deaths due to external causes or poisoning. Coronial inquiries are carried out on one-third of all deaths of Indigenous people compared to one in seven non-Indigenous deaths.⁸ Thus coronial reports are potentially an important source of information on mortality from injury. A National Coronial Information System (NCIS) was begun in 1996, followed by the establishment of the Monash University National Centre for Coronial Information in 1998. The NCIS data set includes an Indigenous status item, but the completeness and reliability of this information will still depend on to what extent police and coroners seek evidence as to whether a deceased person was Indigenous.

Until the 1990s, lack of comparability and variable quality of data seriously constrained the compilation of national hospital data. From 1989, the use of a *National Health Data Dictionary* containing National Minimum Data Sets (NMDSs) has contributed towards consistency and completeness of data collected within hospitals in all jurisdictions. These data were collected using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) until 1997–98, and are now collected using the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, modified for Australian conditions (ICD-10-AM). Data also contain demographic profiles of patients but again, the quality of the data is variable across jurisdictions. The use of the NMDS and ICD standards mean comparable good quality data should be available from all Australian hospitals, but the usefulness of these data for a study of injury to Indigenous people depends on the standard

Continued on page 10

Information about Injury in Indigenous People

continued from page 9

of Indigenous identification. The latter is thought to be acceptable for reporting in the Northern Territory and South Australia since 1998–99 and in Western Australia for the years 1998–99 and 2001–02.

Cases of injury which do not result in death or hospitalisation may be treated by a general practitioner. The BEACH survey, which samples around 1,000 GPs annually, asks questions on Indigenous status of patients. In BEACH data, however, the level of consultation by Indigenous people of general practitioners is low. The survey provides little information on external causes of the injury but does provide information on risk behaviours including risky alcohol consumption.

Another source of information on injury data are large national surveys conducted by the ABS, such as the National Health Survey (NHS). The NHS provides information on health service use, lifestyle factors like smoking and alcohol use and health status. In 1995 around 54,000 people were surveyed and the numbers of Indigenous people sampled was boosted by a supplementary sample to 2,000. Concern about the quality of data from Indigenous people in isolated areas resulted in these data being excluded from the analysis. The 2001 NHS included

3,198 Indigenous people and because of the larger sample size the data provided more reliable estimates for Indigenous people in more remote locations. The next NHS is scheduled to begin in 2004 and will include a sample of around 11,000 Indigenous people which will allow a more reliable regional analysis.

The results of the Indigenous Social Survey 2002 (ISS) will be released later this year. The survey collected information from 12,000 Indigenous people on health, housing, education, employment and social and cultural well-being. Some of the data collected in the ISS which are relevant to injury include lifestyle factors such as risky alcohol use, substance use and being a victim of assault.

Another important large survey is the Community Housing and Infrastructure Needs Survey (CHINS) that includes some information that can be used to assess risk factors for injury, such as flooding, rubbish disposal and access to health care. This survey, carried out in 1999 and 2001, is currently under review. It covers mainly discrete Indigenous communities in rural and remote areas.

The National Drug Strategy Household Surveys (NDSHS) conducted by the Australian Institute of Health and Welfare

have been undertaken every three years from 1985 onwards and include a sample of Indigenous people. The next survey will be in 2004. The 2004 survey will collect information about awareness, attitudes and behaviour relating to drug use.

Other sources of information include local records from intervention programs, ad hoc studies of hospital records on admission for injury, including emergency service records, clinic records, records from community controlled primary health care services and other epidemiological studies. Searchable electronic sources include Medline, which lists articles in journals, the Australian Indigenous Health InfoNet (<http://healthinfonet.ecu.edu.au/>) that provides access to published and unpublished and specially prepared material about Indigenous health issues and the AIHW website (<http://aihw.gov.au>) which has an Indigenous portal (<http://aihw.gov.au/indigenous/index.html>) listing relevant publications.

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Collecting Patient Registration Information

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Background

The poor and uncertain levels of Aboriginal and Torres Strait Islander information in major health and health related collections remains a significant problem across Australia but is more pronounced in NSW.⁹⁻¹³

In 2001 life expectancy for Aboriginal and Torres Strait Islander people at birth was about 20 years less than for the total population, 56 years for Indigenous males compared to 77 years for all Australian males and 63 years for Indigenous females compared to 82 years for all Australian females.¹⁴

The ABS publication, *Causes of Death: Australia 2001*¹⁵ states that while it is considered likely that virtually

all Indigenous deaths are registered, a significant proportion are not identified as Indigenous. Therefore, the number of Indigenous deaths registered in 2001 is an underestimate of the actual number of deaths.

This problem is not only confined to death registrations, it is a significant issue for many administrative collections such as hospital records, birth registrations, and data collected by community service providers that are a major source of information about Aboriginal and Torres Strait Islander people. Unfortunately, Indigenous people are not accurately identified in many of these data collections and one of the main reasons is because they or their relatives or friends are not

asked the Aboriginal or Torres Strait Islander origin question.¹⁶

In 1998 Debbles et al¹⁷ estimated the number of people identified as being of Aboriginal and Torres Strait Islander origin in the Hospital Inpatients Statistics Collection (ISC) was 33% less than expected. In another study in 2003¹⁸, under-reporting of the Indigenous status of patients at a maternity hospital was quantified to be approximately 65%.

These studies, amongst others, cite a number of reasons for the under-reporting of Aboriginal and Torres Strait Islander origin information. These reasons include a reluctance of clients to identify their Indigenous status, a lack of awareness of

Continued on page 11

Collecting Patient Registration Information

Continued from page 10

the need for clients to self disclose this information and a reluctance of clinical and administrative staff to seek information about Indigenous status. Further, the inconsistent use of classification standards, standard collection protocols, and quality control mechanisms as well as the limited ability to validate data limits the capacity to collect accurate data on Indigenous status.

More recent reports^{11,13} have again identified methods for improving the identification of Aboriginal and Torres Strait Islander origin. These include recommendations for both methodology and data enhancement. States and territories have begun developing and implementing initiatives aimed at improving the quality of Aboriginal and Torres Strait Islander origin information in hospital separations data. Some of these initiatives include the development of policies and training programs for staff involved in data collection.

This is a description of the development of the *Collecting Patient Registration Information Training Program (CPRITP)*, which is targeted at front-line staff who collect data in NSW public hospitals.

Program development

The *CPRITP* is based on the *Training Program for Health Staff Collecting Patient Registration Information* designed to train front-line hospital staff to improve the accuracy of patient registration information. This training program was implemented in a number of Area Health Services in NSW through 2000 and 2001.

Other training programs which aim to improve Indigenous status identification, notably those of Queensland Health and the Australian Bureau of Statistics, were reviewed and lent some expertise in developing this program to ensure its suitability and appropriateness.

The *Training Program for Health Staff Collecting Patient Registration Information*, was reviewed and feedback from participants and facilitators indicated that the training focussed too much on Aboriginal health issues, was too long and relied on the involvement of Aboriginal Health Workers to facilitate (or assist in) the training sessions. Anecdotal evidence also suggested this caused confusion as to the purpose of the training and led to the sessions being perceived as Aboriginal Cultural Awareness training. This confusion was perpetuated by the fact that many

sessions were conducted concurrently with existing Aboriginal Cultural Awareness programs.

As a result of this feedback, specific modifications including a focus on overall data quality, reduced emphasis on the broad Aboriginal cultural issue, a reduction in time to a one hour session (to increase ability to transfer the training into the workplace), introduction of a role play where participants practice asking specific questions (enables participants to feel more confident in applying session learnings to the workplace) were incorporated in to the development of the *CPRITP*.

Finally, pilot training sessions were organised and promoted by a range of staff from Human Resource Development to Medical Records and Administration Managers as opposed to the Aboriginal Health Workers and Liaison staff who were heavily involved in implementing the original *Training Program for Health Staff Collecting Patient Registration Information*.

Method

Participants

Three Area Health Services participated as pilot sites in the development of the *CPRITP*. Two urban and one regional Area Health Services participated in 21 pilot training sessions. Additionally, two regional Area Health Services provided valuable feedback and input into the training session development.

Procedure

Area Health Services were initially recruited as pilot sites opportunistically when they made contact to implement the original, *Training Program for Health Staff Collecting Patient Registration Information*.

Formal requests to participate in the pilot were sent to the Area Health Service, Chief Executive Officer and following endorsement, discussions were then held with the senior hospital representatives to introduce the project and identify procedures and appropriate staff to support the pilot. Hospitals were asked to identify a central contact person who could coordinate the training sessions.

Training Program

In summary the objectives of the session are to: identify the importance of collecting accurate and complete information; raise awareness of data items that may be difficult to collect; and review some strategies that may be used when dealing

with difficult situations. The training outcome is that, at the end of this session, participants will be able to confidently ask all questions required at patient registration and understand the importance of obtaining this information.

Results

Training sessions were conducted from March until May 2002. Over this period, 21 sessions were conducted and 175 participants were trained.

Staff from the Department of Health supplied the training material and conducted the majority of sessions. The number of participants in each training session varied from four to 19. While training a larger number of participants was obviously more economical, the smaller sessions were very productive and the informal atmosphere encouraged discussion.

Information was collected from participants prior to commencing the session by using a pre-training questionnaire; results were used as the pre-intervention baseline data. At the completion of each session, participants completed a session evaluation to obtain feedback regarding the effectiveness of each component of the program and overall applicability to the workplace. Between two and four weeks after participation a follow-up (post-training) questionnaire was mailed to all attendees. The questionnaire reflected the same questions contained in the pre-training questionnaire to allow some comparison and measurement of self reported change in work practices.

Training Session Evaluation Summary

175 participants attended the training sessions. Of those, 141 participants completed the training session evaluation forms, representing 81% percent of all attendees. It was from these evaluation forms that the following data have been collected and analysed. These forms were useful in measuring the relevance of content to the participants work role and in assessing the participants understanding of the importance of collecting accurate data. It is agreed that these data rely on self reported information.

The training session evaluations collected indicate that 97% of participants rated the overall content of the training session as above average and the trainer's delivery was rated as above average by 98% of the participants. Forty-one percent of participants considered the trainer's delivery "Excellent".

Continued on page 12

Collecting Patient Registration Information

Continued from page 11

The resources used in the session were rated as “Excellent” and “Very good” by the majority of participants, the most popular being the first part of the video and the least popular the role-play.

The expectations of the training session were “Met completely” for 76% of participants and at least partly met for the remainder. 95% of participants advised they would recommend the session to colleagues.

One of the most positive results evident in the training session evaluations was that 85% of the respondents reported an “improved understanding of the importance of collecting accurate patient registration information” with 61% indicating a “Significant” improvement.

Although the training session was focused on overall data quality in all aspects of patient registration, the participants were asked if they expected to receive training in specific areas. The respondents identified: Aboriginal Cultural Awareness (68%); Handling difficult situations (60%); Interviewing patients (55%); Entering data onto the computer system (52%); and Who uses the information (52%).

Participants were generally happy with the length of the session. A small number (7%) considered the session too short, a lesser number (3%) considered it long. It needs to be emphasised to trainers that, in order to adhere to the timing, group discussion needs to be limited to the very relevant issues. It could be suggested that discussion could continue with the trainer and interested participants after the session.

Pre and Post Course Questionnaires Summary

Of the 175 training participants, 168 (95%) submitted pre-training questionnaires and 95 (57%) submitted post-training questionnaires. The pre-training questionnaire was completed prior to the training commencing (usually while waiting for all participants to arrive). The post-course questionnaire was completed between 2 and 4 weeks later. Where possible these were matched individually to enable a more comprehensive analysis of results.

The questionnaires were designed to collect base-line data about existing work practices and then to collect data about work practices of the participants soon after the training session. This information assisted in: measuring any change in participants efforts to collect specific aspects of patient registration; identification of what may effect the

participant’s capacity to ask specific questions; and assessing the participant’s understanding of why collecting quality data is important.

In the pre-course questionnaire, 26% of participants indicated that they “Never” ask the question on Indigenous status, however on the post-course questionnaire only 14% reported “Never” asking, a reduction of 12%. This was reflected in an overall increase of 12% in the number of participants who reported asking the question between the pre and post questionnaire. In the post-course questionnaire the number of participants who reported asking the Indigenous status question “Most times” almost doubled from 12% to 22%.

In the pre-course questionnaire, 41% of participants reported “Never” asking the question relating to D.V.A. status. This number fell in the post-course questionnaire to 29% with 32% of participants “Always” and 17% “Most times” asking this question. Post-course questionnaire showed an overall increase of 11% of participants reporting asking the question on D.V.A. status.

“Patient reaction” increased as a factor affecting capacity to ask questions following training. It may be concluded that this outcome is a result of participants actually asking the questions more often and therefore became more aware of patient reaction.

Evaluation of pre and post course questionnaires indicates that there has been a definite change in the work practices of participants that attended training. The questions are being asked more often, participants are more aware of the important reasons for asking and are more confident in doing so.

Conclusion

The *Collecting Patient Registration Information Training Program* was well received and strongly supported by management and staff of the Area Health Services and hospitals that participated as pilot sites.

Evidence gathered from the participants, via pre and post course questionnaires and evaluation forms, enabled some measurement of the impact of the training on work practices as well as the effectiveness of the training session. It is evident from these evaluation tools that the training was successful in meeting the desired outcomes—patient registration questions are being asked more often, participants are more aware of the

important reasons for asking and are more confident in doing so.

Also evident is the fact that data quality is a significant concern in relation to a range of data items, not just Indigenous status. To address these concerns religion and Department of Veterans’ Affairs status were selected for inclusion in the pilot (and final training program) because of their sensitive nature and financial implications. Their inclusion also served to divert the emphasis from Indigenous status to overall data quality. These findings were reflected in the training program outcome—participants will be able to confidently ask *all* questions required at patient registration and understand the importance of obtaining this information.

Analysis of pre and post training questionnaires shows that there has been a positive impact on the work practices of participants overall. Results show that since returning to the workplace participants have increased their efforts to collect Indigenous status by 12%, Department of Veterans’ Affairs eligibility by 11% and religion by 15% when registering patients.

The most positive outcome of training indicated by the analysis of pre and post course questionnaires was the significant reduction in the number of participants who reported “I don’t think I need to ask everyone” as the main factor affecting their capacity to ask the question on Indigenous status. This fell from 24% of participants according to the pre-course questionnaire to 6% following training. Participants also indicated more confidence in asking this question as 5% less participants reported “Confidence in asking the question” to be an issue affecting their capacity to ask the question on Indigenous status.

The *CPRITP* clearly identifies improving data quality as the purpose of the session. It also contains limited content on Aboriginal health issues, so as not to detract from achieving its outcome.

Another factor which contributed to the success of the training pilot was the use of Learning and Development Units as the mechanism for promoting and distributing the program throughout Area Health Services. This was in contrast to previous programs which relied on Aboriginal health staff. Despite efforts to market the pilot of the new program as “data quality training”, analysis of

Continued on page 13

Collecting Patient Registration Information

Continued from page 12

the session evaluations showed a high expectation among participants that Aboriginal cultural awareness would be included in the content. This result may be attributed to pre-existing attitudes and misconceptions among hospital staff that Aboriginal health is an issue for Aboriginal health workers to address and that collecting Indigenous status is the responsibility of Aboriginal health workers.

It is imperative that promotion of this training program avoids the misconception of a link to Aboriginal cultural awareness and also that implementation within mainstream learning reinforces the concept that addressing Aboriginal health is the responsibility of all hospital staff.

It is anticipated that as a result of successfully implementing the *CPRITP* NSW Health will achieve information of sufficient quality to support informed decision making about health service

planning and delivery and to evaluate their impact on Aboriginal and Torres Strait Islander health in NSW.

Further details and copies of the Training Program can be accessed on the web site located at

<http://health.nsw.gov.au/im/ahisu/>

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From the Coroner

Child car restraints

In January 2001, a young boy from a small town north of Adelaide was fatally injured in a collision between his mother's car and another vehicle. The injuries he sustained caused respiratory and then cardiac arrest, which led to his death. The injuries were found to have been caused by forward propulsion onto the adult seat belt, which impacted across the neck, and subsequent motion that caused the boy to slide underneath the seat belt. The young boy had been seated on a booster seat, which the coroner (Wayne Chivell) concluded was not anchored to the seat of the car at the time of collision, but relied on the adult seat belt for restraint. Correct adjustment of a seat belt should see the belt pass low and snug across the hips (not stomach), and then goes across the child's chest and shoulder (not neck). Post-mortem examination (by Professor R W Byard, Forensic Pathologist, Forensic Science Centre, Adelaide) concluded that if the adult seat belt had not been properly adjusted, the force of the impact of the collision would have caused forward and then downward movement of the body, the belt catching under the neck of the victim.

Careful examination of the booster device was carried out by Dr Ron Somers (Head of the Injury Surveillance and Control Unit, SA Department of Human

Services). Dr Somers found that although manufactured in 1979, there was no damage to the device, and that it appeared to be in good condition. However, the installation instructions that would originally have been attached to the base, were not present. Dr Somers and Prof Byard gave evidence that, in the absence of the directions, correct installation and usage of the booster seat and its anchor strap would be difficult. In the course of his investigation, Dr Somers also found that sharing or onselling of such safety devices was common, and that the risks of a damaged, outdated or flawed product might not be obvious to parents. Dr Somers suggested to the coroner that the use of booster seats be made mandatory for children 4 to 8 years of age, in line with car restraint legislation for younger children and infants.

Whilst agreeing with this recommendation, Coroner Chivell noted that action for legislation would lie with the Ministers for Transport for each jurisdiction, who meet regularly for the purpose of considering such issues, and that he was unaware of any discussion or action which might be current.

Based on Dr Somers's report, the coroner did recommend that "The Minister for Transport, in consultation with organisations such as the Royal Automobile Association of South Australia Inc, Kidsafe Child Accident Prevention

Foundation of Australia, and any other relevant organisation, consider ways in which the following aims can be achieved" (Finding of Inquest Number 15/2003 (0019/2001)):

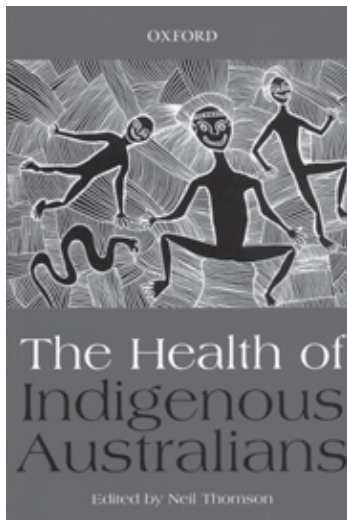
- the use of booster seats in motor vehicles for children between 4 and 8 years be encouraged;
- such booster seats should comply with the relevant Australian Standard;
- such booster seats be properly installed, seeking professional help from the Royal Automobile Association of South Australia Inc or similar organisation when in doubt;
- the use of worn or damaged booster seats should be avoided;
- booster seat manufacturers should consider installation and use instructions in easily understandable language;
- booster seat manufacturers should consider attachment of installation and use instructions which would not deteriorate before the end of the life expectancy of the device;
- further consideration should be given to whether the use of booster seats in motor vehicles in relation to children between 4 and 8 years should be made compulsory.

Detailed findings can be accessed at

<http://courts.sa.gov.au/courts/coroner>

Something to read ...?

The Health of Indigenous Australians



Abstract reprinted with permission from the Australian Indigenous HealthInfoNet.

Edited by Neil Thomson, Centre for Public Health, Edith Cowan University, this book documents evidence of the health status of Australia's Indigenous people and links it to policy and program implications. Taking a public health approach, detailed information about health conditions is placed within a broad social framework. Chapters on population; the economic and social context of Indigenous health; and births, deaths and hospitalisation assist in setting the scene. Detailing an extensive range of available evidence, chapters on specific health topics provide up-to-date summaries on the most important conditions affecting Indigenous people.

Available at book stores and on the Oxford University Press website for \$69.95, <http://au.oup.com/opener.asp>

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

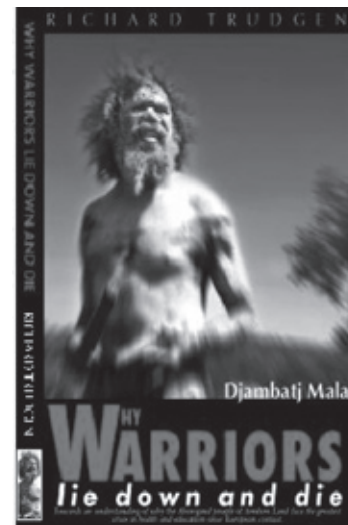


Released in two volumes, this publication reports on the Injury Prevention Activity Among Aboriginal and Torres Strait

Islander Peoples Project which examined the current state of injury prevention activity for Aboriginal and Torres Strait Islander people. The report was prepared for the National Public Health Partnership by Jerry Moller, Neil Thomson, Janette Brooks and Kathleen Clapham.

Both volumes of the report are available, in *pdf* format, on the Department of Health and Ageing website: http://health.gov.au/pubhlth/publicat/document/metadata/inj_atsi.htm

Why Warriors lie down and die



In Arnhem Land the situation is dire: health is poor, unemployment rife and life short. Written by Richard Trudgen, *Why Warriors* provides a fresh analysis of this crisis and offers examples of how the people can once again take control of their own lives.

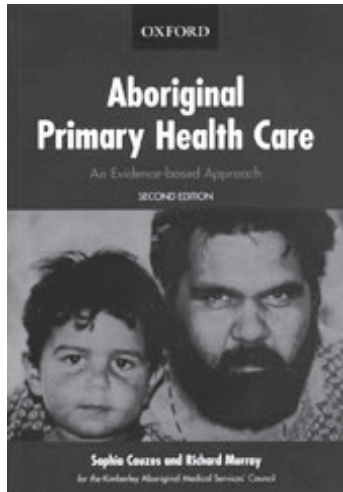
Reviewed by Marion Maddox, Uniting Church Studies, Vol. 7 No. 1, March 2001.

Don't be deceived by its straightforward, accessible style: *Why Warriors Lie Down and Die* is no easy read. During two stints totalling twenty years as a community development worker in Arnhem Land, Richard Trudgen saw Yolngu (Aboriginal) communities deteriorate. He saw diseases once scarcely known, such as scabies, diabetes, heart attacks, stroke and renal failure, become endemic. In the early 1970s, Yolngu people 'found death usually in old age;' by the mid-1990s, elderly Yolngu had become a rare sight, with 'people...dying in their early to mid forties or even younger, and at such a rate that life seems to lurch from one funeral to another.'

The book is available at book stores for \$29.95 and further information is available from: ARDS, PO Box 36921, Winnellie NT 0821, Phone: 08 8982 3444 Fax: 08 8982 3499, <http://ards.com.au>

Something to read ...?

Aboriginal Primary Health Care: an evidence based approach



Edited by Sophie Couzos, National Aboriginal Community Controlled Health Organisation and Richard Murray, Kimberley Aboriginal Medical Services Council, this book follows the first edition published in 1999. It provides an updated overview of: Aboriginal health policy; health services; working partnerships and preventative strategies. The book highlights best practice models developed by Aboriginal community controlled health services and aims to assist those working in the field of Aboriginal health to understand the evidence-base behind primary care interventions. A range of specific health conditions are described within the context of the underlying poverty, overcrowding, and poor nutrition affecting Aboriginal people.

Available at good book stores and on the Oxford University Press website for \$95, <http://au.oup.com/opener.asp>

Editor's Note

The *Injury Issues Monitor* is the journal of the Research Centre for Injury Studies at the Flinders University of South Australia.

Letters to the Editor are welcome.
Editor: Renate Kreisfeld
Guest Editor, Edition 30: Yvonne Helps

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Diary

Note: where available, Internet addresses have been provided below for conference websites. For those meetings that don't have their own website, detailed descriptions of the events are normally available at our website: www.nisu.flinders.edu.au/events/

4th annual NSW Safe Communities Symposium

28-29 July 2004

Sydney, New South Wales

Contact: Jennie Pry, NSW Safe Communities Capacity Building Program, Tel: +02 9858 7973 (Mon, Wed & Thurs), Mobile: 0405 452 512, E-mail: jpri@doh.health.nsw.gov.au

Definitive Surgical Trauma Care Course

28-29 July 2004

Sydney, New South Wales

Contact: Charmaine Miranda, Trauma Department, Liverpool Hospital, Tel: +61 2 9828 3928, Fax: +61 2 9828 3926, E-mail: charmaine.miranda@swsahs.nsw.gov.au

SWAN XII Trauma Conference

30-31 July 2004

Sydney, New South Wales

Contact: Thelma Allen, Trauma Department, Liverpool Hospital, Tel: 61 2 9828 3927, Fax: 61 2 9828 3926, E-mail: thelma.allen@swsahs.nsw.gov.au Website: www.swsahs.nsw.gov.au/livtrauma/meetings

10th World Conference on Transport Research

4-8 August 2004

Istanbul, Turkey

Contact: Cumhuriyet Cad. 173 Kat:7, 80230

Elmaday-Istanbul, Turkey Tel: +90 212 232 4885 Fax: +90 212 232 4889 E-mail: aybenkokum@tourselect.com.tr Website: www.wctr2004.org.tr/

Workshop: Focus Groups

6 August 2004

Adelaide

Contact: South Australian Community Health Research Unit, Flinders University, Tel: 08 8204 5988.

Workshop: Qualitative Interviewing and Analysis

6 August 2004

Adelaide

Contact: South Australian Community Health Research Unit, Flinders University, Tel: 08 8204 5988.

17th International Conference on Alcohol, Drugs and Traffic Safety

8-13 August 2004

Glasgow, Scotland

Contact: ICADTS T2004 C/- Meeting Makers, Jordanhill Campus, 76 Southbrae Drive, Glasgow G13 1PP, Scotland, UK Tel: +44 141 434 1500, E-Mail: icadts2004@meetingmakers.co.uk Website: www.icadts2004.com

2nd International Conference WORKINGonSAFETY.net

31 August to 3 September 2004

Dresden, Germany

Contact: WOS 2 Conference Secretariat, Koeningbruecker Landstrasse 2, D-01109 Dresden, Germany Fax: +49 351 457 20 1106 E-Mail: wos@hvbg.de Website: www.workingsafety.net

5th International Summit: Healing our Spirit Worldwide

1-5 September 2004

Cairns, Queensland

Contact: Conference secretariat, Tel: +61 7 5471 3161, E-mail: indigenousconventions@westnet.com.au Website: <http://indigenousconferences.com.au>

Australian Conference of Ambulance Professionals Conference 2004

9-11 September 2004

Alice Springs, Northern Territory

Contact: ACAP 2004 Conference Secretariat Tel: 08 8922 6232.

Workshop: Consumer Feedback

10 September 2004

Adelaide, South Australia

Contact: South Australian Community Health Research Unit, Flinders University, Tel: 08 8204 5988 Fax: 08 8374 0230

7th Australian Injury Prevention Conference and Pacific Rim Safe Communities Conference

15-17 September 2004

Mackay, Queensland

Contact: Maria Lamari, Conference Secretariat, PO Box 3090, Norman Park QLD 4170, Fax: +617 3847 2148, Website: <http://aipn.com.au>

2004 Australian Conference of Science and Medicine in Sport

7-9 October 2004

Alice Springs, Northern Territory

Contact: Rainer Wilton, Conference Manager, Sports Medicine Australia PO Box 237, Dickson ACT 2602, Tel: +61 2 6230 4650 Fax: +61 2 6230 5908, E-mail: sma.conf@sma.org.au Website: www.sma.org.au/acsms/2004/

Workshop: Evaluation

8 October 2004

Adelaide, South Australia

Contact: South Australian Community Health Research Unit, Flinders University, Tel: 08 8204 5988 Fax: 08 8374 0230

Workshop: Evaluating Arts and Health

8 October 2004

Adelaide, South Australia

Contact: South Australian Community Health Research Unit, Flinders University, Tel: 08 8204 5988 Fax: 08 8374 0230

Workshop: Population Health, Planning and Spatial Perspectives

5 November 2004

Adelaide, South Australia

Contact: South Australian Community Health Research Unit, Flinders University, Tel: 08 8204 5988 Fax: 08 8374 0230

Road Safety Research, Policing and Education Conference

14-16 November 2004

Perth, Western Australia

Contact: Impact Communications Pty Ltd PO Box 8440, Perth WA 6849 Tel +61 8 9227 0233, E-mail: roadsafety@impcom.com.au Website: www.impcom.com.au/roadsafety/conference2004/

Definitive Surgical Trauma Care Course

16-17 November 2004

Melbourne, Victoria

Contact: Lyn Journeaux, Trauma Offices, Royal Australasian College of Surgeons, Tel: +61 3 9276 7448, Fax: +61 3 9249 1298, E-mail: lyn.journeaux@surgeons.org

1st Australian Falls Prevention Conference

21-23 November 2004

Sydney, New South Wales

Contact: Annie Butler Prince of Wales Medical Research Institute Barker St, Randwick NSW 2031 Australia E-mail: a.butler@unsw.edu.au Fax: +61 2 9399 1005 Website <http://powmri.unsw.edu.au/AFP2004>

Asia-Pacific Conference on Public Health

29 November to 3 December 2004

Brisbane, Queensland

Contact: Brian Oldenburg, School of Public Health, Queensland University of Technology, Tel: +61 7 3864 3925, E-mail: b.oldenburg@qut.edu.au Website: www.apacph.org

5th International Course: Global Burden of Injury

18-22 April 2005

Stockholm, Sweden

Contact: Moa Sundstroem, Karolinska Institute, Tel +46 8 517 779 48, E-Mail: moa.sundstrom@smd.sll.se

8th World Conference on Injury Prevention and Safety Promotion

19-22 March 2006

Johannesburg, South Africa

Contact: Conference Secretariat, Tel: +27 12 4812094, Fax: +27 12 4812112, E-Mail: sec@safety2006.info Website: www.safety2006.info

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