

# 10. The Community Perspective

## What do injuries mean for Aboriginal people?

### Stories relating to specific injury events

The following is a compilation of stories, quotes and comments, which resulted from the focus groups, interviews and event-narratives. There were so many stories acquired during the course of this study it was almost impossible to exclude any. Everyone who shared their injury experiences and emotions further highlighted the cause, nature and effect that injury has on the individual, family and community as a whole. It should be noted that information such as the persons name and the community from which they are from, has been intentionally omitted in order observe the confidentiality rights of individuals.

Hit & Run - 26 year Male:

*I was returning home from town at about midnight after going to a football game followed by a nightclub. I was walking along the side of the road there were no footpaths at the time. I was hit by a car from behind I don't remember anything about the accident. A taxi driver found me lying in the middle of the road near the centre lines, apparently he stopped his car right near me so if any cars came along they won't run over me, he called an ambulance. I was taken to hospital with a broken pelvis; two broken legs including smashed knee, tissue damage to my right upper arm, multiple lacerations and bruising, and was unconscious for two days. I was in hospital for 16 days and then at home in a wheel chair for two months. I have had to have a few operations on my knee since the accident. I use to be a 1<sup>st</sup> grade football player on the wing but because of the accident I will never play again and this makes me very depressed. I haven't been able to work either, my family and friends have helped out a lot and have supported me through it. I have just started getting legal help.*

Car Accident – 40 years female:

*I was hitch hiking home a drunk fella stopped and picked me up. There were four other people in the car. He missed the corner we went straight into a paddock and rolled the car a few times. I had a big cut on my head, a blood clot over my eye, back injury and multiple cuts and lacerations. The ambulance came but instead I went in the paddy wagon to the hospital. I got treatment at the hospital that night then went home with stitches and two black eyes. I still have headaches and back pain.*

Push Bike Accident – 17 years female:

*I was riding my bike with a friend on the road somewhere when I fell off hard and hit the road face first. The skin from my jaw to up past my nose was completely pulled back off my face and I had skinned my knee to the bone. I got 102 stitches in my face and needed plastic surgery. The hospital treated me well and put me in a ward. I ended up being out of action for a few months. I only got these scars around the creases in my nose and on my chin, most people can hardly notice them aye!*

Work Injury – 42 years – male:

*I was an assistant property manager on a farm, shearing sheep, pressing wool and stacking bales of wool which weighed up to 200kgs. I had been in the job for about 10 years. This day I was lifting a bale onto another one when I felt a sharp pain in my lower back. I stopped work to rest my back for about an hour then went back to work. The next morning I went to get out of bed when sharp pain hit in my back again, I couldn't move. I went to A&E had x-*

rays, they referred me to a specialist who said I had done nerve damage. I was given Valium and was off work for 8 weeks on compo. When I went back to work I had to do light duties for about 4 months then went onto another job and the same problem occurred. I now have ongoing back problems ever since the accident and am getting arthritis in the lower back.

Physical Assault – 21 years male:

*I was in a nightclub just drinking and dancing with cousins, I wasn't really that drunk but could feel the effects of alcohol. My wallet was stolen while I was on the dance floor. I left the club because a few friends and cousins (girls) were outside they were too young to come in. I went over to the girls to get them away from the boys who were fighting with them, and then the boys turned on me. They were punching, kicking and trying to choke me when the police turned up, they (local white boys) then ran off. I knew I was hurt because I felt pain in my face and had bruising around my neck. I didn't go for treatment straight away because I was too scared to leave the house. I went to the clinic 3 days later, they sent me to A&E for x-rays. A&E said I had a fractured jaw, gave me pain medication and referred me to John Hunter Hospital. I had to attend outpatient clinic there a few times. It was 6 months ago now, I still won't go to town on my own and my brother still wants revenge every time he sees them because of what they did to me.*

Domestic Injury – 36 years female:

*About 12 months ago I went shopping on a Saturday morning at my local supermarket. I stooped down to get an item and cut my forehead on a hook, which was sticking out of the shelves. The manager of the super market came to my aid and I reported it. I went home my head was still bleeding, I took some panadol. Later that night I got sick and had a headache so I rang the hospital they said they were very busy but to stay awake and if it got worse to come up. I ended up going the next day to A&E who said I had concussion. Now I suffer headaches, loss of concentration and neuralgia and I have a noticeable scar on my forehead, which I am self-conscious about, so I have to wear a fringe. I have sought legal advice and hope to be compensated for medical expenses.*

Sports Injury – 46 years male:

*About 2 months ago I was playing touch football, I was running and sidestepped away from a defending player. I felt a click and my left knee became very inflamed and filled with fluid I went to a GP and was referred to a specialist who drained it about 3 times. I think years of football and training has worn down and degenerated my knees this has made me more susceptible to injury. The hardest thing is the realisation that my knees are totally stuffed and the mental impact that has had on me. Sport was a discipline, a way of life, my career. If I did it over again I would have only played for 5 to 6 years professionally. If someone had told me what would happen to my body I wouldn't have played so long. This will effect me in my elderly years. Athletes should be better informed about the impact that training has on the body and ways to prevent injury in their chosen sport.*

Snake Bite – 30 years male:

*A couple of days before Christmas my son got bitten on his thigh and stomach by a snake. I could see the puncture marks even without my glasses on. We had been having a little drink and were a bit drunk. I took him straight up to the A&E, the doctor there said he couldn't see any bite marks, I told him to get a magnifying glass because I could see them without my glasses on. The doctor said he didn't think it was a snakebite and sent us away. A couple of days later he was in a lot of pain his leg and stomach went black and he had pain in his side so we went down to the GP and he called an ambulance straight away. When we got to the hospital the doctor there said he had to go straight into surgery for his leg and stomach, plus he had gone into kidney failure. If only the doctor listened the first time this wouldn't have been as bad. We didn't have a great Christmas that year.*

Bike Accident – 29 years male

*I was riding to work on my pushbike in the designated bike lane at 8.20am, which I have been doing for the past 11 months because of financial constraints, and to get fit. I was riding around a bend changed up a gear and pedaled harder. Because I was in the bike lane I felt safe and knew I could keep my head down to watch out for glass and potholes. I was doing about 40klms an hour when I ran into the back of a stationary van parked illegally in the bike lane. I don't remember anything about the actual accident; I was unconscious and was taken to hospital by ambulance. They put me on morphine and did x-rays, head scan and monitored me for about 5 hours. They said I had done muscle fibre and soft tissue damage to my neck, shoulder and back, and had a bruised jaw and sore teeth. Because of the accident I was unable to go to work for 2 weeks, suffered headaches and pain, was unable to get physically comfortable and couldn't provide care and support to my wife and daughter. Now I have no means of transport.*

**Burns Injury – 32 years female**

*I was on holidays visiting extended family at a government home for kids. I was piggybacking my 2 yrs old cousin and we ran into the kitchen. We ran straight into a tray of hot cooking fat, which my aunty was carrying, hot fat went everywhere all us. I was burnt the most, my nose to my chin, my neck and shoulder, my arm and breast, and my stomach. They put us in a car and drove for 1 hr to the nearest hospital; I was airlifted to Prince of Wales Hospital in Sydney. My cousin got 2nd degree burns to arms and legs, my aunty got 1st degree burns to her arms. I was in hospital for 3 months with 2nd and 3rd degree burns and had to have 2 skin grafts. My aunty had a nervous breakdown, dad was always traumatised when he came to visit me in hospital and mum had a D&A problem, which increased as a result of my accident. When I was released from hospital I was passed around the extended family because they were all concerned that they didn't know how to care for me. The problem was there was no support nor education for them from the health system.*

**Car Accident – 49 years female:**

*On my way home had been out at the pub with friends, I got a lift home, 4 people were in the front and I was in the back of a ute with a friend. We went around a corner after overtaking a truck and went off the side of the road and into a ditch, I was thrown in the air and think I landed on my back on the sides of the tray of the ute. I came too for a minute and touched a leg which I thought was the other women's, it was cold and I thought she was dead, but when I looked it was my leg, then I passed out again. I was in hospital for 9 months, 3 months in bed and 6 months rehab. I had a T8 break to my spine, broken ribs, broken collarbone, chipped knee and multiple lacerations. The community was in shock and my family had to help take care of my children. I had to wear a brace for 9 months, take a lot of medicine and have been in a wheelchair ever since. I have never let it get me down, I have got on with my life. I have been to technical college, done voluntary work, participated on committee's, worked at TAFE coordinating education programs and run a basketball knockout comp.*

**Motor Bike Accident – 40 years male:**

*I was motocross riding in the bush just having fun on a weekend my friend was about ½ hour behind me. My bike hit a tree root in the ground it through me into another tree, I was travelling at about 80 to 100 klms an hour at the time. My friend came along and found me, he got me home. The next day my friend took me to the hospital because of the pain. I had done ligament and soft tissue damage to both knees, sprained my arm and wrist, and had broken some ribs. I was out of action for about 3 months, I could stand-up net alone work. I now get pain in my knees in winter and one knee seems to give way from time to time when I'm walking.*

**Recreational Injury – 19 years female:**

*It was the weekend I was roller-skating with friends. I went down a hill and couldn't stop, I fell backwards and landed on my hands and felt a snap. I went home and dad took me to A&E and we sat there for ages. I had a x-ray they said I had fractured my wrist and put a half slab plaster on my arm and I had to have it in a sling for about 2 weeks. I couldn't play sport, go to karate lessons or write for a few weeks but I still went to school.*

Sports Injury – 20 years male:

*I was playing soccer on the weekend, it was a pre-season trial. I was on the field and went to jump-up to the ball when my knee gave way and twisted, I heard a click. The next morning I went to A&E, they x-rayed me and said I had torn the cartilage off the back of my kneecap. They referred me to a specialist, that was 2 weeks ago and the appointment isn't still for another 4 weeks. I can't play soccer because my knee is still swollen and I can't walk properly. Six weeks is a long time to wait to get something done.*

Burns Injury – 3 years female:

*I was in a hurry ironing my jeans on a table when my daughter put her hands up along the edge of the table to stabilise her self, she was just starting to walk. I didn't see her fingers on the edge of the table and accidentally ironed over 3 of her fingers. She started screaming and I didn't know what had happened until I saw her fingers. I took her straight up to A&E the doctor saw us right away, I was in heaps of shock couldn't believe it shaking and everything and was told to wait outside. While I was waiting outside the doctor must have assumed child abuse and called DOCS. Because by the time she had the skin grafts done to her fingers and was transferred to a ward DOCS had put an order on me refraining me from unsupervised visits and taking her home from hospital when she was better. She was in hospital for 1 week, I visited her everyday and had to be supervised. I had to attend court to regain custody of my child and prove myself, all this with no support from the system. This was all as a result of an innocent accident and a hospital which over reacted.*

Sports Injury – 19 years female:

*I was at netball training at my local club doing a normal training session running around the field to warm-up prior to the game. While I was running I tripped on uneven gravel and fell on my wrist, my wrist felt funny and everyone said it will be ok it's probably just a sprain. I went home and told my parents that I think it's broken and they didn't believe me and said it's probably just a sprain. The next day I was in a lot of pain, it was swollen so my dad took me to the GP, he said that he thought that it was broken and sent us to A&E. After waiting there for about 6 hours I had an x-ray and they put a plaster cast on it. That stayed on for about 6 weeks and then I had to have physiotherapy. My dad felt real bad about it and kept saying sorry all the time. It's ok now I just can't turn it as well and sometimes it clicks.*

Sports Injury – 41 years male:

*I was playing a weekend reserve grade football game when I got tackled by 2 other players. In the tackle one of the guys came over the top of me and landed on my shoulder, I heard it crack but got up and continued to play anyway. The next day I was in big pain so went up to A&E. They x-rayed me and found that I had fractured my collarbone and torn a muscle in my shoulder. I was in heaps of pain for about 2 weeks and had to wear a sling. I wasn't able to go to work or play football for a couple of weeks.*

Push Bike Accidents - sister and brother

a) 14 years male

*He was riding his bike in the school grounds when the bike slid sideways on the loose gravel and he fell off. He slid on the gravel on his side and took skin off his arms and hands but the main injury was he ripped open his kneecap badly. I (father) took him to A&E after the school had rung me to tell me to take him to the hospital. The doctors had to numb his knee so they could scrub the gravel out and stitch him up. He was on crutches for about 4 days and wasn't allowed to play any kind of sport for a couple of weeks, during that time he drove us*

*all stupid. For a long period he was very accident prone, he got bitten by a snake, cut himself with a knife, got a fishhook stuck in his finger, he was run over by a pushbike, bitten by a dog and had hit his head hard on the ground after falling off his skateboard.*

*b) 7 years female*

*It was Christmas 1999 my daughter was riding her brand new bike with her helmet on down a hill when the brakes failed and the cable snapped. The road was a dead end, she hit the gutter, went over the handlebars and flew through the air for about 35 feet and landed in a garage. Her sisters were there they ran home to get their mother, she took her straight to the hospital and I met them there and had to carry her in. She had 2 broken bones in the right wrist, 1 broken bone in the left wrist, broken collar bone, broken teeth, fractured jaw, pierced ear drum, split chin which needed 8 stitches and multiple cuts and bruises. They put her into intensive care then flew her down to John Hunter Hospital for surgery to wrists, chin and jaw. You know she never cried once or asked for painkillers, she's a strong kid. She stayed in hospital for 2 weeks then when she came home she needed full-time care and support for 6 months. She had to go to the specialist every month for 8 months and now she has ongoing specialist appointments every 6 months for the next 6 years.*

*You know nothing like all this bad luck has ever happened to our family before, until we moved into this other house. They say that the people here before us had played around with black magic and a young boy had killed himself in the house. I reckon we had goong (bad spirits/evil forces) in the house and that these people had stirred them up because close by there is an old ceremonial site. We have had people from the church out to the house a couple of times trying to sought it out. The spirit of the young boy doesn't worry me because he is good goong it's all the bad goong that's the problem, you just don't muck around with that stuff (spirits), you respect it, especially when there is a site so close by.*

### **What effect does injury have on Aboriginal people?**

Responses to the question "What sort of effect do you think these injuries have on the people injured, their families and communities?" are as follows:

- miss out on school
- unable to work
- loss of income and stressed out
- worry about who the next person will be to get hurt because the problem never gets fixed
- people don't worry too much about minor injuries there just the norm
- community members and families are very concerned about major injuries
- added pressure to provide more care and support by family and friends
- people seem to get more stressed out if kids are injured
- kooris seem to have a bigger pain tolerance so it has to be pretty bad before it gets treated
- lasting effects like hiding away, denial and depression
- increased alcohol consumption
- if it's violence people turn a blind eye and mind their business unless it's real bad
- community gets concerned and angry because they talk but nothing gets done or don't know how to deal with it
- family and Aboriginal health workers always provide care
- it lowers people's self esteem and injury becomes a way of life
- depends on how it happened a lot of people deny cause of injury because of shame and stigma
- cultural discrimination when you have to be treated has a big impact
- disruptive and hard to get around because of the lack of transport

- injury resulting in death has a huge impact on the community for years
- families tend to worry more than they show
- families break up because hospitals call police or DOCS depending on person injured, that's why most of our people prefer not to get treatment at hospital but go to the clinic or not bother at all.

## **Core issues**

### **Environment**

The area covers around 25,000 square kilometres and includes eight Local Government Areas. The physical environment varies considerably throughout the geographical area of the Mid North Coast as it extends along the NSW coastline from south of Bulahdelah to the north of Woolgoolga and west out to Stroud. Some communities are located right on the coast where others are up 60 klms inland.

Although there are common themes in relation to the nature and cause of injury there are considerable differences with regard to the physical environment in which they occur. Communities located close to towns reported a higher degree of violence in public areas, racial related violence and pedestrian injury compared to members of outlying communities. For communities located in outlying areas they were more exposed to issues relating to access of transport, risks associated with travelling on dirt roads, limited lighting and a lack of services in general. Other obvious differences were those located nearer to the coast or rivers were more likely to sustain leisure related injuries caused from swimming, surfing, jumping from bridges, oyster hunting and fishing.

The following environmental themes associated with injury were identified across a number of the communities involved in this study.

- Poorly maintained sports fields
- Poorly maintained roads
- Lack of pedestrian and push bike pathways
- Inadequate lighting (roads and pathways)
- Lack of pedestrian crossings
- Inadequate transport options
- Proximity to ocean and rivers
- Inappropriate access to fire trails
- Lack of recycling facilities
- Excess hard waste and poor waste management
- Poorly maintained homes
- Insufficient or poorly maintained playground equipment

### **Services**

The following agencies/services were identified by respondents as playing a major role in the reduction of Aboriginal injury. These agencies/services were also seen as having neglected the areas in which Aboriginal communities are located and had not performed their core functions in relation to addressing hazardous problems: Road and Traffic Authority, Local Councils, Population Health Division (Environment Health Unit, Aboriginal Health & Aged Care Services), North Power, Department State Forest, NSW Police Service, Aboriginal Community Controlled Organisations (Medical Services, Land Councils, Youth Services and Aged Services), Department Sport and Recreation.

There was a clear sense of disbelief from community members regarding the lack of equality of services provided to mainstream communities compared to that of Aboriginal communities located within an active ex-reserve (mission).

Although the respondents identified the aforementioned agencies/services as having a mandate to rectify hazardous problems, it was also acknowledged that the communities themselves could play a significant role in taking some of the responsibility. Respondents highlighted the need for community members, with assistance from other services, to become more actively involved in addressing these problems, by taking more pride in the community environment in which they live. Community members reported that Local Councils receive untied grants based on the Aboriginal population within their LGA. It was frequently expressed that these grants should be used to assist in addressing problems such as those identified, or to enhance the capacity of existing Community Develop Programs currently located within local Land Councils.

## **Priorities for action and opportunities for injury prevention**

The following responses were made in relation to what respondents considered to be of highest priority and requiring immediate action in order to minimise the prevalence, cause and impact of Aboriginal injury on the Mid North Coast.

### **Education/Awareness**

- develop greater community awareness about ways of preventing injury
- develop regional programs to ensure consistency throughout the area and result in a greater impact
- more relevant education/courses eg. D&A, first aid, lifesaving, swimming certificates, self esteem and relationship courses, money management
- educate them while they're young, take injury prevention into schools
- address interpersonal violence eg. domestic violence, assault, sexual assault,
- run sport safety courses
- home safety courses eg. cooking, fire, electricity, baby hazards in the home
- create interest by developing something that youth would want to be involved in eg. driver safety course, car maintenance course, supervised stock car races, koori surfing club/competition, koori fishing club

### **Health and community services**

- elderly aids eg. walking frames, rails, ramps
- alcohol and drug counsellors, self help groups, family support groups
- emergency after hours community clinic, on call nurse/doctor, trauma support, safe house for victims of domestic violence
- gambling counselling and support
- increase transport options for outlying communities and late at night
- domestic violence, assault and sexual assault counsellors and support groups

### **Environmental**

- more community involvement and consultation eg. roads, bypasses, freeway off ramps, bus stops, changes to policy
- communities are rate payers and should get the same services as everyone else
- get central community recycling depots for glass, tin and paper
- clean-up community campaigns (ATSIC, local sponsors, community awards etc.)
- create safe sites for community gatherings eg. barbeques, fire pits, running water, shelter and waste bins
- get lighting on footpaths for night safety

- get pedestrian crossings or overpasses
- street/road maintenance in and around communities eg. proper footpaths built or fixed, grates over drains or canals fitted or repaired, potholes filled, street cleaners

### **Employment**

- employ qualified alcohol and drug counsellors within the community
- employ quality staff who specialise in only one area and know what their doing
- provide professional accredited training in priority areas of injury
- community development programs employ more Aboriginal people to work on hazardous areas in communities
- increase employment generally and it will improve peoples self esteem and reduce boredom, violence and alcohol use in the communities

### **Who should be involved in making a difference?**

During the formal and informal qualitative phase of the project it became evident that community members were harmonious in their response to the question “who should be involved in making a difference?”.

- Aboriginal Community members
- All relevant Aboriginal Community Controlled Organisations
- Aboriginal Liaison Officers from any relevant department
- NSW Health Department
- MNC Aboriginal Health Partnership Committee
- MNC Area Health Service
- Local Government
- Local Shire Council’s
- NSW Police Service
- Road and Traffic Authority
- Department Sport and Recreation
- Local Businesses
- Community Clubs
- Self help groups

Respondents further elaborated by adding that they would like the “Partnership” to adhere to the priorities identified in the Aboriginal Health Strategic Plan; increase its commitment to all communities on the Mid North Coast by ensuring equality in health funding; and enhance the communities opportunities for community consultation and negotiation. It was also acknowledged that communities are chronically disillusioned by promises being constantly broken by most sectors of Government in relation to health and their environment.

# 11. Moving Forward: Future Plans and Partnerships

All information acquired during the course of this project has proven to be invaluable in identifying meaningful, practical and attainable solutions to Aboriginal injury reduction and ultimately prevention. The correlation between environment and behaviour should never be underestimated, nor should the cultural mores in which they function.

In addition, any of the proposed initiatives should be developed to have clear and achievable outcomes, which can be measured and/or modified.

## Short term priorities

*(within one to two years)*

- The establishment and successful implementation of an Mid North Coast Aboriginal Injury Prevention Working Party through which the recommended actions of this report will be prioritised and then further developed, implemented and evaluated. The Committee would need to be endorsed as a sub-committee of the Mid North Coast Aboriginal Health Partnership Steering Committee and would require a membership of key stakeholders from all relevant communities, services, agencies and departments eg. RTA, Police, Local Government, Shire Councils, Population & Environmental Health, Land Councils, Aboriginal Medical Services etc.
- The development of a best practice model in community environmental safety assessment and inter-governmental liaison is urgently required. 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 development and implementation of appropriate education and awareness programs, and courses is an essential component to positive change in behaviour, environment and service utilisation. To facilitate this process, the identification and availability of physical and monetary resources from a cross section of key services, agencies and departments is essential, and can be co-ordinated through the specialised Working Party. The development and publication of a Mid North Coast community calendar listing all relevant courses, education programs, promotion campaigns and events including contact details would be distributed to all Aboriginal communities, service providers and relevant agencies. This would lead to an increase in awareness of services, access and the utilisation of numerous initiatives.

The priority areas for education, promotion and awareness were identified:

- regional community injury prevention awareness programs
- alcohol & other drug community education campaigns
- First Aid courses
- Aboriginal lifesaving programs
- Aboriginal learn to swimming program
- self esteem and relationship courses
- money management education
- school injury awareness programs

- domestic violence, assault, sexual assault awareness education campaigns
  - sports safety and injury prevention programs
  - home hazards awareness and safety courses
  - learner driver assistance program (assist in practical tuition and theoretical development in order attain a learner and/or probational licence)
  - road safety program (pedestrian and push bike awareness)
- Additional training for medical staff (incl. CME points) and nursing staff of A&E Dept's in relation to the effects of alcohol and other drugs and cultural awareness.
  - Data collection processes need to be adopted by all clinical staff of A&E Dept's to ensure consistency and accuracy in routine data collection systems for the purpose of accurate surveillance.
  - Alternative approaches for the provision of health and community services needs to be developed to improve access and availability to Aboriginal communities. This may require the development of outreach services, after hours on call clinical staff in local clinics, satellite clinics or courtesy transport for the following issues: aged care, alcohol and other drug counsellors, self help groups, family support groups, medical emergency treatment, trauma support, gambling counselling and support, early childhood, youth support, domestic violence/ physical assault/ sexual assault counsellors and support groups.
  - A commitment by NSW Health to the development and implementation of an NSW Aboriginal Injury Prevention Strategy is integral in the reduction and prevention of Aboriginal injury.

## **Long term priorities** *(within five years)*

- In order to adequately address community concerns in relation to injury risk and issues pertaining to poor environmental management, it is essential that a comprehensive program be implemented. The proposed program would be consistent with the best practice model and would require the employment of four Aboriginal Safety Assessment and Liaison Officers (two in the southern region and two in the northern region of the Mid North Coast) one of which would be team leader. The main elements and benefits of the program would include:  
enhanced assessment practices of hazardous issues identified by the community, reduced response time in rectifying hazardous issues identified, one local contact for a number of government agencies and services, direct liaison with officers at identified agencies, reduction in community complaints, increased utilisation and access to government initiatives and/or services by communities, inter-governmental collaboration in the development of an priority environmental hazard checklist, enhanced and appropriate consultative processes, improved and safer community environments, increased pride in community, reduction in community frustration and reduced risk of injury.

The program officers would further assist and involve communities to achieve:

- community clean-up campaigns (in conjunction with other relevant campaigns)
- community involvement and consultation eg. roads, bypasses, freeway off ramps, bus stops, changes to policy
- central community recycling depots for glass, tin and paper

- create safe sites for community gatherings eg. barbeques, fire pits, running water, shelter and waste bins
- lighting on footpaths for night safety
- pedestrian crossings or overpasses
- street/road maintenance in and around communities eg. proper footpaths built or fixed, grates over drains or canals fitted or repaired, potholes filled, street cleaners

In order to achieve outcomes and ensure sustainability the program would report directly to the “Partnership” via the “Working Party”, and would require absolute endorsement from the Premiers Department to ensure the involvement and support of all relevant agencies and services.

It has been anticipated that the model for the proposed program is comprehensively developed as a short-term action within in six months, during which time a thorough consultation process with all key community and agency stakeholders will occur.

- In order to increase the capability of effective injury surveillance, it is essential that NMDS-IS level 1 is revised to include “cause of injury” and not only basic data related to injury events, in terms of: a narrative description; main external cause; intent; type of place; type of activity; nature of injury; and body region.
- Research needs to be undertaken to examine the impact that alcohol consumption and Aboriginality of patients has on A&E Dept medical and nursing staff, and how this influences clinical judgement and treatment times.
- The establishment of safe houses for victims of interpersonal violence and alcohol intoxication is essential in the reduction of Aboriginal injury.
- A commitment by all government departments to increase Aboriginal employment by providing opportunities to gain qualifications in specialised health and environmental fields.

## **Creating a living partnership and developing the structure for making decisions**

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.

It is imperative to recognise that no matter how many times injury prevention is identified in local, state or national strategies or plans it is the Aboriginal communities of the Mid North Coast that will have ultimate control over the success, scope and future of any such initiative or partnership. Through discussions with community members it is apparent that the primary platform for which an effective inter-sectoral partnership can be built is one of openness, trust, commitment and sustainability.

It is essential that Aboriginal communities, members and key agency are involved equally throughout the entire process to develop and maintain injury prevention partnerships across all relevant communities and agencies. This includes thorough and open consultative and negotiation processes, conducted at times, venues and locations deemed appropriate to the needs of that community.

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.

The optimum outcome will be the establishment and successful implementation of an Mid North Coast Aboriginal Injury Prevention Working Party through which the recommended actions of this report will be prioritised and then developed, implemented and evaluated.

It would be expected that the Working Party develop formal mechanisms for reporting to key committees across all sectors of the Mid North Coast. It would then anticipated that these committees report on the local progress at state and national levels.

However, in the interim there are many existing infrastructures into which many injury prevention initiatives could immediately be facilitated. Many committees throughout the Mid North Coast are well established and able to promote the development of injury prevention initiatives at a local level. There are other opportunities such as task forces and working parties where there mandate clearly overlaps with one or more of the directions or priority areas of Aboriginal injury prevention, this should be seen as an opportunity and utilised wherever possible.

Involvement with State, National and International injury prevention organisations and conferences will further assist in gaining support and fostering enthusiasm for the development of local injury prevention initiatives.

## 12. Conclusions

The findings from this study will not only enable the various decision-making bodies and the Aboriginal communities of the Mid North Coast with the required information to establish appropriate initiatives to reduce the prevalence and impact associated with injury. It will also provides sound base line information to assist in the development of a much-needed NSW Aboriginal Injury Prevention Strategy.

### Health System Impact

- Further research needs to be undertaken to examine the impact that alcohol and Aboriginality has on the medical and nursing staff and how this influences waiting times at A&E Departments.
- The large majority of Aboriginal injury presentations (61%) triaged as semi-urgent (response time up to one hour). Qualitative findings revealed that a majority of community members had experienced waiting times of three to six hours. The reasons for this discrepancy need to be looked into and should include an assessment of “reasonable staffing levels”.
- The use of qualitative methods were found to be the most accepted means of identifying the causal chain of events leading to injury, by providing a safe environment for which community members could share a personal account of their experiences and opinions relating to injury.

- 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, in terms of: a narrative description; main external cause; intent; type of place; type of activity; nature of injury; and body region.
- A&E data was found to severely underestimate the incidence of Aboriginal injury. Using corrected estimates data the real incidence rate among Aboriginal people on the Mid North Coast is six to seven times that of non-Aboriginal people.
- Aboriginality is reportedly asked of all people attending A&E Dept's and recorded in the Emergency Department Information System (EDIS) its accuracy is mostly reliant on administrative staff, and in most cases only until 7pm. It was apparent that the priority for clinical staff is medical treatment and not administrative duties. An alternative system needs to be implemented for night staff, which will ensure accuracy of information.
- Qualitative findings revealed that most Aboriginal people would go to a community clinic first, attend A&E only if the clinic was closed or the clinic referred them there. This was found to be associated with fear of rejection and/or judgement, excessive waiting times, shame if alcohol was involved or lack of transport. Alternative treatment services need to be explored for after hour emergencies within communities.

### **Environmental Impacts**

- Although there are common themes in relation to the nature and cause of injury there are considerable differences with regard to the physical environment in which they occur. Communities located close to towns reported a higher degree of violence in public areas, racial related violence and pedestrian injury compared to members of outlying communities. For communities located in outlying areas they were more exposed to issues relating to access of transport, risks associated with travelling on dirt roads, limited lighting and a lack of services in general.
- There was clear evidence to support community concern regarding the lack of equality in service provision and access to facilities for Aboriginal communities located within an active ex-reserve (mission) to the that of mainstream communities on the Mid North Coast.
- Poor environmental management was identified as a leading contributor to the risks associated with and the prevalence of Aboriginal injury. The correlation between poor physical environment and risk related behaviour should never be underestimated.

### **Physical Impacts**

- Of the total 12,212 injury presentations to the three A&E Dept's 797 were recorded as being of Aboriginal status. Although Aboriginal people only represent 3.2% of the Mid North Coast population Aboriginal injury represents 7%.
- Aboriginal people residing in the northern region of the area (Port Macquarie to Woolgoolga) constituted for 71% of all Aboriginal injury presentations to an A&E facility in the area.
- The rates of injury among Aboriginal males were found to be only marginally higher than their female counterparts, and predominantly effected those aged 15 to 39 years.

- The study found that 48% of injury occurred in and around the home or within the community setting, 17% occurred in a recreational place (external to community setting) and 11% was attributed to road trauma.
- Regardless of differing community lifestyles and physical environments the study identified resounding commonalities in the type of injuries sustained. Lacerations, sprains/strains and contusions were the large proportion of all injury presentations to A&E Dept's. Other injuries of concern were cranial injuries, fractures and poisoning's.
- Three quarters (73%) of all Aboriginal injury was solely attributed to leisure activities.
- Injuries which were sustained as a result of alcohol, drugs, domestic violence or fighting were considered by the members of various communities to be intentional or deliberate acts.
- Although the data indicated that interpersonal violence accounted for 19% of injuries the communities involved in the project considered it to be much higher. The combination of alcohol, financial hardship, low self esteem and impoverished environmental settings are considered to be the major factors in most cases.
- The study identified an overwhelming correlation between alcohol and the following: interpersonal violence; falls; lacerations and transport related trauma. Informal sport was also particularly evident as a main cause of injury in the qualitative findings, however, it was found to be reported as leisure in the quantitative data.
- Hospital data recorded 34% of all Aboriginal injury presentations occurred over the weekend period with a prominent increase on Saturday for all communities across the Mid North Coast. Injuries which occurred late in the evening or in the early hours of the morning were not dealt with immediately because they were either unaware of the severity of the injury, or would wait until they were sober or until transport was available. This accounts for the rapid increase in injury presentations to A&E Dept's from 7am to 10am. The increase in people presenting between 4pm and 8pm was found to be reflective of the availability of clinical services within the community setting after 4pm.

### **Communities Response**

- 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.
- Not 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, will there be evidence of positive change.
- The optimum outcome will be the establishment and successful implementation of an Mid North Coast Aboriginal Injury Prevention Working Party through which the recommended actions of this report will be prioritised and then developed, implemented and evaluated.
- Aboriginal Injury initiatives encompassing community education and awareness, increased access to relevant health and community services, positive environmental changes, increased employment opportunities and increased societal opportunities in relation to employment and social activity were considered to be of priority.