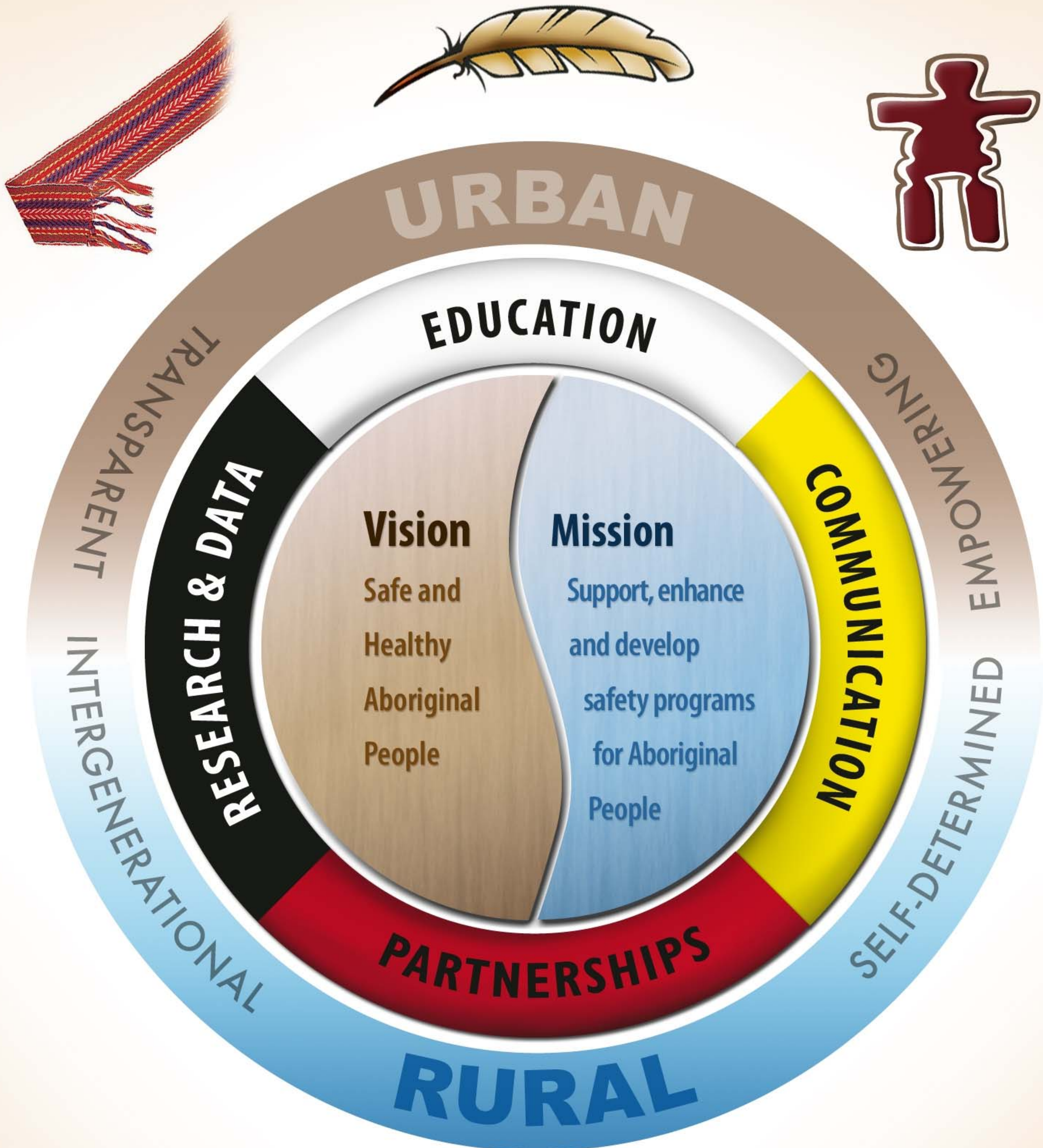
Aboriginal Injury Prevention Model

Alberta



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Injury Prevention Project
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Production of this document has been made possible through a financial contribution
from the Public Health Agency of Canada.
The views expressed herein do not necessarily represent the views of
the Public Health Agency of Canada.

March 2007

Acknowledgements

The Alberta Centre for Injury Control and Research (ACICR) extends special thanks to the Elders for the wisdom and support they contributed to this project. Appreciation is extended to all members of the Project Working Group for their contributions and guidance and to all individuals who participated in the focus group consultations.

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1.0 BACKGROUND

1.1. What we know

Health data clearly tells us that injury is a significant health issue affecting all Canadians with Canada's Aboriginal population being at greater risk.(1) Death rates due to injury are four times greater among Aboriginal people.(2,3) In Canada's western provinces injury among Aboriginal people represents the leading cause of death with the highest rates of injury deaths being recorded among those aged 0-44 years.(4) We also know that approximately 50% of all persons identified as being of Aboriginal origin live in urban areas.(2) Despite these key facts, the injury problem among urban and rural non-reserve Aboriginal populations receives limited attention.

Steps forward have been advanced primarily by First Nations on-reserve communities. In large part this progress is linked to more discrete jurisdictional mandates associated with the provision of services and programming for First Nations residing on-reserves. The First Nations and Inuit Health Branch, Alberta region and other government branches have provided support for planning processes and community-based injury prevention initiatives.

In contrast, however, very few initiatives and resources are being directed towards addressing injury as a critical health issue among Aboriginal people (Métis-First Nations-Inuit) living in urban and rural settings. In order to address this gap, strategic and coordinated efforts are required to address the problem of injury within this target group.

1.2. Barriers to action

Factors such as the:

- *lack of clarity regarding jurisdictional mandates;*
- *lack of knowledge and limited data about injury issues affecting non-reserve Aboriginal populations (Métis-First Nations-Inuit);*
- *lack of dedicated resources; and*
- *lack of formalized systems of partnership*

continue to create barriers to action. These barriers present unique challenges in establishing inter-governmental and inter-organizational working relationships. In an

effort to address these barriers this project was undertaken to develop a culturally relevant Aboriginal injury prevention model for the purpose of developing a guide for action on the problem of injury.

1.3. Approach

The development of the Aboriginal Injury Prevention Model was a collaborative process undertaken over a 15 month project period. The overall development of the model was guided by the *Urban Aboriginal and Rural Métis Settlement Injury Prevention Working Group*, a group formed to guide the project. The developmental process included an environmental scan of current injury prevention activities as well as focus group meetings. Information gathered was synthesized and reviewed by the working group and used to develop a model for action. An initial model was drafted and revised based on working group feedback.

1.4. Purpose of model

The model represents a ***guide for action*** on injury affecting urban and rural Métis, First Nations, and Inuit people that is culturally relevant. The purpose of the model is:

- to provide focus and direction for injury prevention activities and resources in Alberta,
- to promote working partnerships that support culturally relevant and self-determined action on injury at provincial, regional and local levels, and
- to develop capacity to plan and deliver targeted injury prevention services and programming.

2.0 KEY ELEMENTS OF THE MODEL

The model focuses on Aboriginal people (Métis, First Nations and Inuit) living in urban and rural environments. The model specifically recognizes that a significant proportion of Aboriginal people live and work in urban and rural communities. The model also places emphasis on a holistic perspective which is fundamental to Aboriginal people. There are distinct needs among Aboriginal cultural groups and populations, however commonalities exist with regards to a holistic worldview and the determinants of health as understood and experienced by Aboriginal people.

Determinants of health reflective of an Aboriginal worldview have been developed by the *Four Worlds International Institute for Human and Community Development.* During the development of the *model* these determinants were echoed in focus group discussions emphasizing the ongoing impacts of colonization on generations of Aboriginal people.

1. Basic physical needs
2. Spirituality and a sense of purpose
3. Life-sustaining values, morals, and ethics
4. Safety and security
5. Adequate income and sustainable economies
6. Adequate power
7. Social justice and equity
8. Cultural integrity and identity
9. Community solidarity and social support
10. Strong families and healthy child development
11. Healthy ecosystem and a sustainable relationship between human beings and the natural world
12. Critical learning opportunities
13. Adequate human services and social safety net
14. Meaningful work and service to others

The Four Worlds International Institute for Human and Community Development, Determinants of Health

Cultural integrity and identity was core to all discussions around which other determinants were discussed. Clear to Aboriginal people and less understood and accepted by non-Aboriginal people is that cultural connectedness and Aboriginal to Aboriginal approaches are factors that protect from injury and promote resilience.

Although all determinants were touched upon and could be related to injury, several recurring themes were linked to personal health practices, coping skills, poverty, literacy levels, unemployment, access to health services and funding. Common points of reflection were as follows:

- Individuals engaging in risk taking behaviors such as unsafe sex and drug use are at higher risk for injury.
- Inadequate coping skills, mental health issues, and low self-esteem place individuals at higher risk for injury.
- Poverty and low income levels impact the ability of individuals and families at many levels to make safe choices and adopt safety practices. For example, basic physical needs will take priority over the purchase of car seats and helmets.
- Low literacy levels present a barrier to reaching target groups often most at risk for injury.

- Unemployment is a significant issue facing Aboriginal populations. Lack of employment is connected to multiple facets of well-being such as the ability to provide for basic family needs and a sense of purpose and security.
- Access to prevention as well as treatment services is dependent upon regional infrastructures, relationships, funding, knowledge about available resources and physical proximity. Management of health services appears to be largely short-term in nature and crises oriented.

These discussions clearly emphasized that multi-generational impacts can only be addressed through long term planning and sustained commitments to action. Recognition exists that proactive approaches associated with Aboriginal cultures have grown weak and it is important to nurture, regain and strengthen these approaches. It is the belief of the working group that action on injury can be forwarded by: sharing knowledge and resources; promoting the understanding of issues facing Aboriginal people; and working in partnership.

2.1. OUR VISION: Injury prevention activities aimed at reducing the problem of injuries are guided by a vision of *'Safe and Healthy Aboriginal People'*. This vision speaks to the holistic view of life fundamental to Aboriginal people. By extension the prevention of injury is connected to living in balance with the elements of life and living a healthy lifestyle individually and collectively.

2.2. OUR MISSION: In support of a holistic vision it is essential to actively and strategically support safety programs targeted for Aboriginal people. Critical to achieving our vision is to ensure that current programming efforts continue to receive support. Current programming must be maintained and enhanced while new programs are needed to address current and emerging issues.

2.3. KEY FOCUS AREAS: Our vision and mission can be achieved by focusing on four key areas, these being: education, communication, partnerships, and research and data. It is understood and expected that these focus areas will vary based on local and regional injury issues as well as capacity related to skills, resources, infrastructure and leadership.

2.3.1. EDUCATION: Within Aboriginal communities there remains an ongoing need to promote awareness and knowledge about the preventability of injuries. In order to do this effectively, culturally relevant educational approaches and materials are needed to support awareness raising and knowledge development activities. Increased efforts are also required to ensure that safety education is actively incorporated into existing activities, services, and programs using holistic approaches.

At a practitioner and service delivery level educational opportunities are needed for Aboriginal people to develop capacity and skills in the area of injury prevention.

2.3.2. COMMUNICATION: Despite the high rates of injury among Aboriginal people, current social marketing campaigns are rarely designed for Aboriginal people. Culturally relevant social marketing approaches, tools and strategies are required to promote and disseminate safety messaging and information.

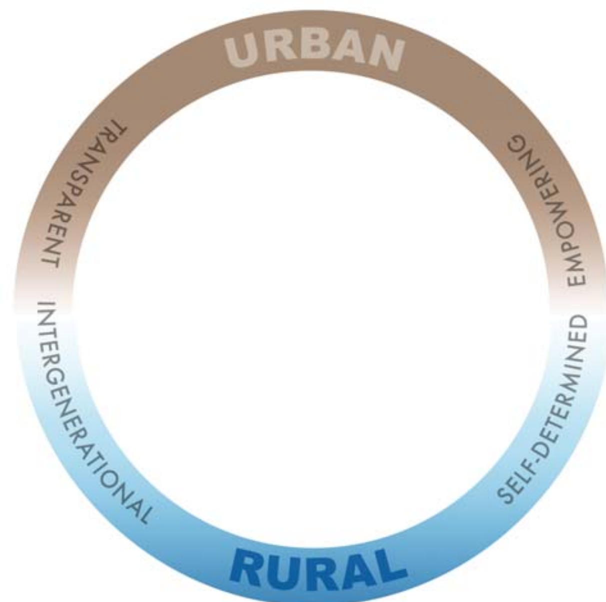
In addition to reaching Aboriginal people through social marketing initiatives there is a significant need to develop structured communication channels among administrators and service providers. Currently the flow of information about available resources, programming, and decision-making is relatively unplanned and inconsistent. General access to information is difficult and time-consuming speaking to the absence of reliable communication networks.

2.3.3. PARTNERSHIPS: The sharing of resources for the interests of the community is valued among Aboriginal people. Today partnerships are a reflection of this value and are considered critical to supporting the development of holistic and integrated services and programs. The development of working partnerships, networks and linkages are considered fundamental to promoting action on the injury problem.

2.3.4. RESEARCH and DATA: There are many limitations associated with Aboriginal health data. Issues around the identity and recognition of Aboriginal people are significant and have resulted in data that are incomplete and inaccurate. Current limitations associated with Métis specific health data make it difficult to draw conclusions from sample data. Ultimately data limitations have a direct bearing on the ability to undertake effective health planning and to lobby for needed resources and programming. This is particularly relevant to injury prevention as information related to the circumstances associated with injury events and the identification of common risk factors drive the development of prevention programming. Data gathering mechanisms are needed at community and regional levels to collect useful and reliable data in support of evidence-based planning.

2.4. VALUES GUIDING STRATEGIC ACTION: Primary to all initiatives is that they be self-determined, empowering, transparent and intergenerational.

2.4.1. SELF-DETERMINED: A key imperative among Aboriginal people is the right to self-determine and take control of their own lives. Culturally relevant and effective services must be guided by Aboriginal people for Aboriginal people.



Fundamental to Aboriginal people is ownership and responsibility for their destiny, well-being, and health outcomes.

2.4.2. EMPOWERING: Traditional Aboriginal ways support positive lifestyles and learning approaches. Culturally appropriate injury prevention initiatives and programs need to support positive rather than punitive strategies. Rewarding and acknowledging healthy and safe choices are basic strategies that will empower Aboriginal people and communities to prevent injuries.

2.4.3. TRANSPARENT: Often health planning affecting or involving Aboriginal populations does not appropriately engage or clearly inform Aboriginal people of intended purposes and outcomes. Injury prevention planning must be guided and informed by Aboriginal people from the initial stages of planning and development through to implementation and evaluation using transparent planning and communication processes.

2.4.4. INTERGENERATIONAL: Every Aboriginal community and culture holds traditional knowledge passed on through Elders and their lived experiences and understandings of life. Elders play a vital role in preserving and passing on their knowledge of life; helping to address problems; and educating youth and communities. At the same time the Aboriginal population is younger and growing faster than the general Canadian population.[5-6] It is believed that effective decision-making, service delivery and programming must use intergenerational approaches involving Elders and young people.

3.0 COMMON INJURY PRIORITIES - AFFECTED AGE GROUPS - RISK FACTORS

Injuries significantly impact Aboriginal people living in both urban and rural environments. Although it is difficult to accurately quantify whether urban or rural injury rates are greater, it is clear that concern related to *motor vehicle related injuries, suicides*, as well as *violence related injuries* are common injury priorities. It is also known that the majority of injuries greatly impact younger age groups regardless of where they live and

work. Risk factors common to both urban and rural environments were identified as being:

- drug & alcohol use (prescribed & recreational);
- access to drug dealers & crystal methamphetamine;
- mental health issues; and the
- acceptance & tolerance of risk taking behavior.

4.0 POPULATION SPECIFIC INJURY PRIORITIES - RISK FACTORS

Focus group meetings undertaken as a component of the project reaffirm that although there are common injury priorities there are also very population specific injury priorities and risk factors.

For example the focus group representing the eastern Métis settlements considered unintentional injuries to be more predominant than intentional injuries. In this population, motor vehicle related injuries and falls among the elderly are designated injury priorities. This is the only population within the project which identified falls as a priority injury issue. On the other hand representatives in the urban and Métis Tri-Settlements focus groups considered intentional injuries to be a more significant problem than unintentional injuries.

Several distinct examples of population specific injury priorities and risk factors were also well in evidence. For example the focus group in Paddle Prairie described community homes being located alongside a highway frequented by forestry and logging vehicles and two rivers. These unique geographic characteristics clearly pose environmental risks for injury specific to the community and its residents. Another example of population specific issues was identified by the Tri-Settlements focus group which recognized limited housing and overcrowding as contributing factors associated with injury. Another environmental risk factor was related to the presence of dogs and wild boar.

Injury problems and injury rates associated with unintentional and intentional injury do vary distinctly by population and community. It is critical that injury priorities and related risk factors be considered in their local context.

This speaks to the need to address common injury priorities experienced by Aboriginal people as well as population specific injury problems and risk factors.

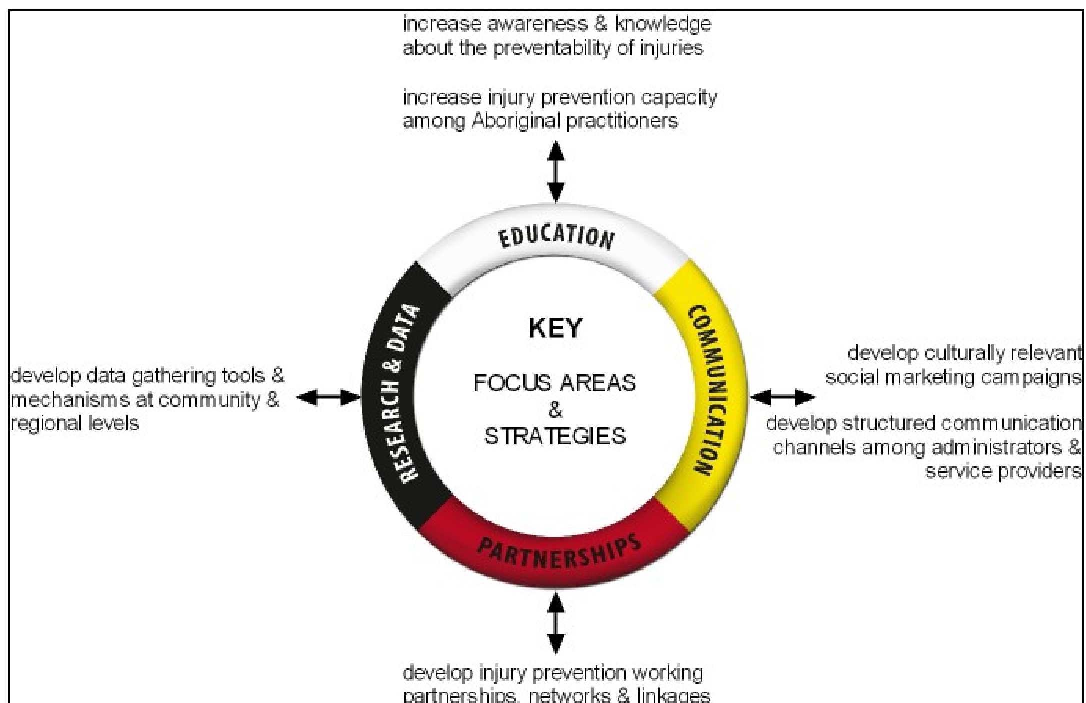
5.0 OVERARCHING INJURY PREVENTION OBJECTIVES

Injury prevention objectives common to both urban and rural Aboriginal people (Métis-First Nation-Inuit) are:

- To reduce the leading *unintentional* causes of injury death, hospitalization and disability due to motor vehicle related injuries
- To reduce the leading causes of *intentional* injury death, hospitalization and disability due to suicide, assault, abuse, and self-mutilation
- To reduce the number and severity of all injuries associated with alcohol and drug use

6.0 FOCUS AREAS AND COMMON STRATEGIES

As previously outlined and as illustrated below, the model defines four key focus areas and details common strategies in each of the areas. These focus areas and strategies are intended to guide the direction of injury prevention efforts which need to be undertaken at both regional and local levels in Alberta.



7.0 KEY BARRIERS TO ACTION

First and foremost is the general scarcity of Aboriginal to Aboriginal approaches which are hindered by the multiple factors listed in the table below. These key barriers to action impact on the ability of Aboriginal populations to act on their injury problems in all four focus areas.

<table>
<tr><th>EDUCATION</th><th>COMMUNICATION</th><th>PARTNERSHIPS</th><th>RESEARCH & DATA</th></tr>
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lack of Aboriginal to Aboriginal approaches
short term planning
lack of information & data
limited number of Aboriginal personnel & facilitators
limited access to trained injury prevention personnel
lack of resources & funding
growing competition for funds
limited bylaw enforcement
arms length relationship with most Regional Health Authorities
unspoken culture of non-interference
limited communication at various levels (organizational, inter-organizational, with target populations, Aboriginal & non-Aboriginal groups)
limited coordination of planning & programming

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8.0 KEY BUILDING BLOCKS FOR INJURY PREVENTION

From an Aboriginal perspective the following building blocks must be advocated:

- Leadership (Aboriginal and non-Aboriginal)
- Proactive approaches supported by long-term planning
- Appropriate levels of dedicated funding
- Evidence-based planning, monitoring and evaluation
- Coordinated and integrated services
- Structured channels of communication and information sharing
- Reliable and usable injury data and research
- Informed and capable Aboriginal workforce

9.0 KEY RECOMMENDATIONS

Based on the work undertaken, the working group recommends the formation of an Aboriginal Injury Prevention Steering Coalition to develop and forward a *5-year action plan* on the following recommendations.

- To advocate for long term planning with sustained injury prevention activities and funding by the province and regional health authorities
- To support the development of population specific injury prevention initiatives
- To develop and provide injury prevention training opportunities for Aboriginal practitioners
- To establish dedicated community-based Injury Prevention Coordinator positions
- To address program access issues
- To address Aboriginal injury data gaps

10.0 NEXT STEPS

At the concluding meeting of the Working Group, a decision was made to strike an interim Steering Committee that would take on the responsibility of ensuring that the Model is promoted and acted upon. The development of the Action Model is the first step in the process that will guide the development and implementation of a five year action plan. As a next step, the commitment to action will be forwarded by the establishment of a Steering Group which will work to secure funding and partnership support to advance the vision of Safe and Health Aboriginal People. Given ACICR's provincial mandate to work in partnership with all stakeholders to reduce injuries, the Centre will continue to actively support the coordination of efforts for this collaborative initiative.

References

1) Unintentional and Intentional Injury Profile for Aboriginal People in Canada, 1990-1999: Minister of Public Works and Government Services, Health Canada, 2001

2) MacMillan HL, MacMillan AB, Offord DR, Dingle JL. Aboriginal health, Can Med Assoc J 1996; 155(11): 1569-78.

3) Bridging the Gap: Promoting Health and Healing for Aboriginal Peoples in Canada. Ottawa: Canadian Medical Association, 1994.

4) Portrait of Aboriginal Population in Canada, 1996 Census: Statistics Canada, 1999.

5) A Profile of the Métis: Target Groups Project: Statistics Canada, Minister of Industry.1996

6) Aboriginal Peoples of Canada: 2001 Census.