



Australian Government  
Department of Health



# National Injury Prevention Strategy

2020 – 2030

DRAFT FOR CONSULTATION

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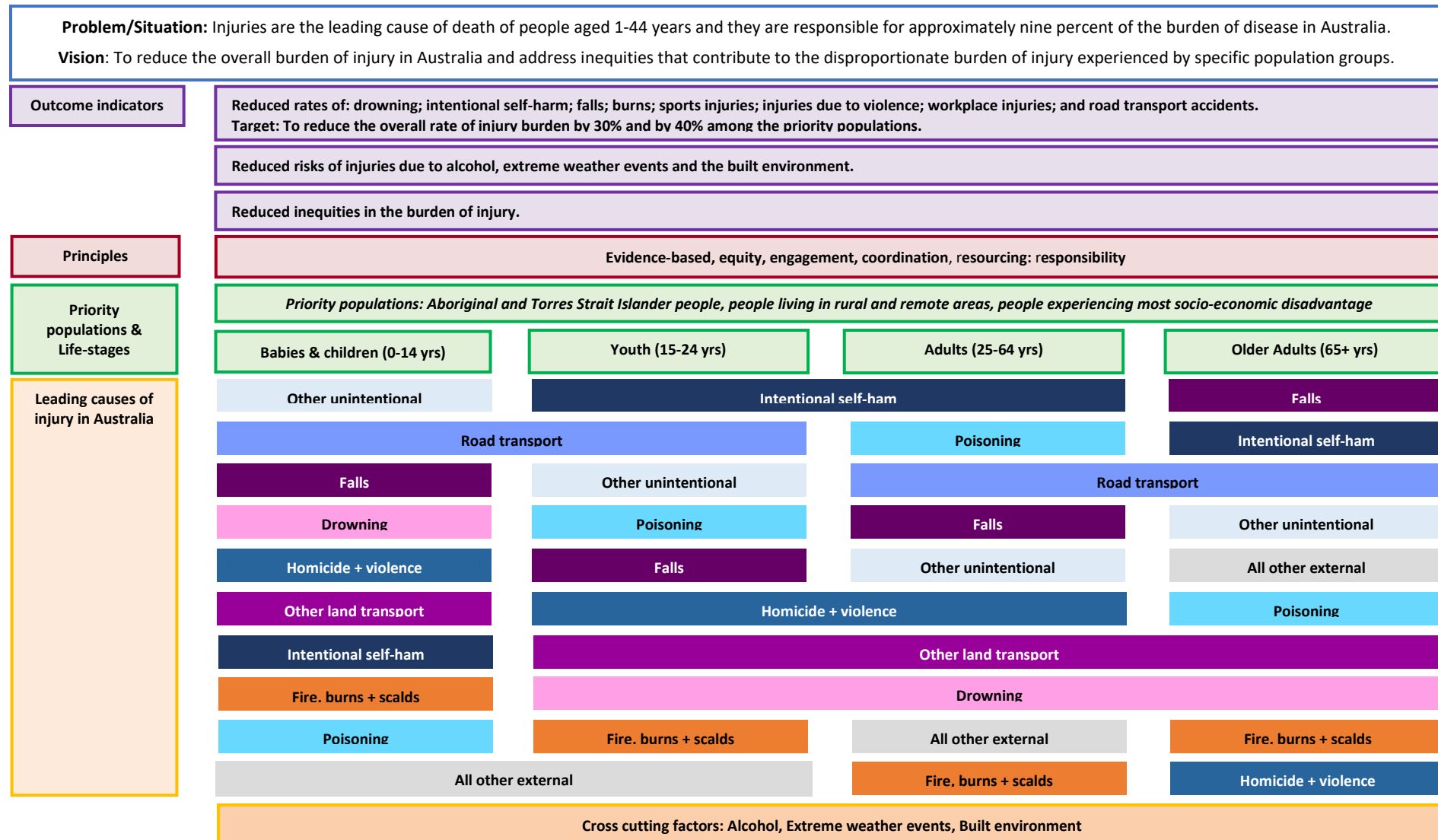
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## Glossary and abbreviations

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ACCOs	Aboriginal Community Controlled Organisations
ACCHO	Aboriginal Community Controlled Health Organisation
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
ECHC	Early Childhood Health Centres
DALY	Disability Adjusted Life Years counts years of healthy life lost through either premature death or disability. It is calculated through adding years of life lost and years lived with disability or in poor health due to disease or injury.
FASD	Fetal Alcohol Spectrum Disorder
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer/questioning
NGO	Non-Government Organisation
NIAA	National Indigenous Australians Agency
PHN	Primary Health Network
Primary prevention	Preventing an injury event from occurring.
Secondary prevention	Reducing the amount of energy exchanged during an injury event or reducing the harm caused during the injury event. Secondary prevention also relates to enhancing outcomes and recovery after the event.

## National Injury Prevention Strategy overview



## 1. Introduction

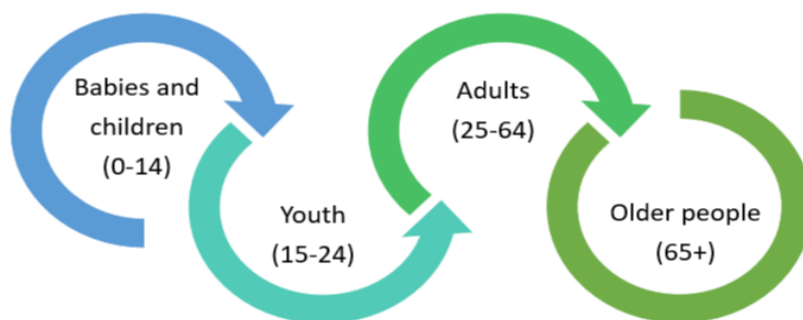
Injuries are the leading cause of death to those aged 1-44 years<sup>2</sup> and are responsible for approximately 9% of the total burden of disease in Australia<sup>3</sup>. While injury deaths fell between 1999-00 and 2004-05, there have been limited reductions since then<sup>4</sup> and since 2007-08, there has been a yearly increase in hospitalised injury cases (at a rate of 1% per year).<sup>5</sup>

The National Injury Prevention Strategy: 2020-2030 (the Strategy) considers injuries in their broadest context: unintentional injuries as well as violence and intentional self-harm. While the data are presented in terms of death, hospitalisations and disability, the Strategy recognises that for communities, families and individuals, the social, emotional, spiritual and economic impact goes well beyond those statistics.

The Strategy aims to create a *national focus on injuries and their prevention*. The Strategy seeks to encourage collective investment and action on evidence-based strategies to prevent the types of injuries with the highest burden for each of the priority population groups. The Strategy nominates these priority areas for action and identifies the lead agencies responsible for injury prevention programs, resourcing, workforce development and providing quality and timely data.

This Strategy takes a **life-stages approach** recognising the role of injury prevention before an individual is born and across the various phases of their life (Figure 1).

Figure 1. A life-stages approach



By examining injury prevention opportunities over the lifespan, the Strategy recognises that healthy childhoods create the greatest opportunity for healthy ageing. As we grow and mature, our environment, our life roles, our behaviour and our physical make-up all change in ways that affect our exposure to injury risks. Accordingly, the recommended actions are grouped into those relevant to each specific life-stage.

Within all life-stages are **priority populations** (Aboriginal and Torres Strait Islander people, people living in rural and remote areas and people experiencing socio-economic disadvantage) which are overrepresented among fatal and serious injuries.

The Strategy also recognises the direct contribution of **cross-cutting factors** to many different types of injury, and the potential for change in addressing these risk factors. These cross-cutting factors are alcohol, extreme weather events and the built environment.

The Strategy's priority actions, are grouped according to **key objectives** (see table on page 3). These can be used to monitor and track the actions and measure progress toward the overall vision. The Strategy will be accompanied by a monitoring and reporting framework to be released in 2021.

Injury type	Objectives	Life stage				Across the lifespan*	Priority populations		
		Children + babies	Youth	Adults	Older adults		Aboriginal	Rural + remote	Low SES
Intentional self-harm	1. Reduce the rate of intentional self-harm		✓	✓	✓			✓	✓
	2. Reduce the rate of intentional self-harm among Aboriginal and Torres Strait Islander people		✓	✓			✓		
Falls	3. Reduce the rate of falls	✓			✓		✓	✓	✓
	4. Reduce falls in public spaces due to better design of public buildings, facilities and paths/walk ways					✓B			
Poisoning	5. Reduce the rate of drug-related poisoning			✓				✓	✓
Road and land transport	6. Reduce road-related injury		✓	✓	✓	✓A	✓	✓	✓
	7. Increase child pedestrian safety	✓						✓	✓
	8. Promote the correct use of appropriate child car seats	✓					✓	✓	✓
	9. Reduce injuries to vulnerable road users through legislation and better design of road infrastructure					✓B			
Homicide and violence	10. Increase primary prevention of violence and equitable access to timely, appropriate and affordable care	✓		✓	✓		✓		
	11. Reduce the prevalence and impact of violence	✓		✓			✓		
	12. Reduce alcohol-related violence in public places					✓A			
Drowning	13. Reduce drowning and near-drowning events	✓				✓A	✓		
Burns	14. Reduce the rate of scalds and burns	✓							
Workplace	15. Reduce the rate of workplace injuries		✓	✓					
Sport	16. Reduce the rate and impact of sports injuries	✓	✓	✓			✓		
Determinants of injury	17. Increase the proportion of families accessing services relevant to the first 2000 days of life.	✓					✓		
	18. Increase proportion of children living in supportive home environments	✓					✓		
	19. Prioritise the availability of and access to culturally appropriate programs and services	✓	✓	✓	✓		✓		
	20. Reduce the use of alcohol, and related harms of alcohol, during pregnancy	✓				✓A	✓		
	21. Reduce injuries associated with housing and public spaces through better design and designs standards					✓B			
Alcohol	22. Reduce alcohol-related harm					✓	✓		
	23. Reduce acceptance of 'alcohol culture' that encourages excessive consumption					✓			
	24. Reduce alcohol-related injuries among those who drink at levels above the recommended guidelines					✓			
Extreme weather	25. Provide timely access to data on weather-related presentations to Emergency Departments or hospital admissions					✓			
	26. Improve the short- and long-term response to climate extremes which include a focus on preventing injuries					✓			
	27. Increase the use of innovative design and technology in transport, housing, and urban infrastructure to reduce the risk of injury associated with expected longer and more severe heat and extreme weather events					✓			
	28. Reduce preventable injuries through improvement of disaster warning and communications technologies					✓			
	29. Improve response to the threat of physical and social impacts of climate change and extreme weather events					✓			
Built environment	30. Improve urban planning to promote health and safety					✓			

\* Cross cutting across the lifespan and injury type, A= cross cutting with alcohol, B= cross cutting with the built environment

## 2. Setting the scene

### Injuries at a glance

Injury is the <b>leading</b> cause of <b>death</b> for Australians aged 1-44 <sup>1</sup>		
In 2015 almost <b>11 000</b> Australians died from injury <sup>3</sup>	<b>189<sup>3</sup></b> <i>Children 0-14 years died from injury</i> #1 cause was Transport accidents <sup>4</sup>	<b>811<sup>3</sup></b> <i>Young people 15-24 years died from injury</i> #1 cause was Suicide + Self-harm <sup>4</sup>
	<b>5118<sup>3</sup></b> <i>Adults 25-64 years died from injury</i> #1 cause was Suicide + Self-harm <sup>4</sup>	<b>4733<sup>3</sup></b> <i>Older adults 65+ died from injury</i> #1 cause was Falls <sup>4</sup>
Many people experience the life-long impacts of injury		
The number of <b>HOSPITALISATIONS</b> due to injury has increased each year over the past decade and now exceeds <b>460,000<sup>2</sup></b>	a) 405 961 DALY from injury <sup>3</sup> b) 334 219 years of life lost due to injury <sup>3</sup>	
Injury affects some Australians more than others		
For almost every year since 2001, <b>Aboriginal and Torres Strait Islander people</b> have had <b>2 X</b> the rate of injury compared to non-Indigenous Australians <sup>6</sup>	People in <b>REMOTE AREAS</b> are <b>2 X</b> as likely to be injured than people in <i>major cities</i> <sup>5</sup>	People living in <b>AREAS OF MOST SOCIO-ECONOMIC DISADVANTAGE</b> are <b>1.4 X</b> more likely to be injured than those in areas with <i>least disadvantage</i> <sup>5</sup>
	People living in <b>Northern Territory</b> have the <b>highest injury death rate</b> <b>1.7 x</b> the national rate. <sup>5</sup>	
Costs to Australia		
Social, emotional and financial costs include: <ul style="list-style-type: none"><li>• Loss of life</li><li>• Hospital</li><li>• Productivity loss</li><li>• Years of good health</li><li>• Impact on family and community</li></ul>	<b>\$8.9 billion</b> in 2015-2016 of recurrent health expenditure alone <sup>8</sup>	
	Work related injury and disease cost the Australian economy <b>\$61.8 billion<sup>7</sup></b>	
<div>1. <a href="https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/leading-causes-of-death">https://www.aihw.gov.au/reports/life-expectancy-death/deaths-in-australia/contents/leading-causes-of-death</a> 2. <a href="https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/injury/overview">https://www.aihw.gov.au/reports-data/health-conditions-disability-deaths/injury/overview</a> 3. <a href="https://www.aihw.gov.au/reports/burden-of-disease/abds-2015-interactive-data-disease-burden/contents/burden-of-disease-in-australia">https://www.aihw.gov.au/reports/burden-of-disease/abds-2015-interactive-data-disease-burden/contents/burden-of-disease-in-australia</a> 4. Burden dataset 5. <a href="https://www.aihw.gov.au/reports/injury/trends-in-injury-deaths-australia-1999-00-to-2016/contents/summary">https://www.aihw.gov.au/reports/injury/trends-in-injury-deaths-australia-1999-00-to-2016/contents/summary</a> 6. <a href="https://www.aihw.gov.au/getmedia/ee82bd99-125f-421e-bbdc-32540f336f98/aihw-injcat-207.pdf.aspx?inline=true">https://www.aihw.gov.au/getmedia/ee82bd99-125f-421e-bbdc-32540f336f98/aihw-injcat-207.pdf.aspx?inline=true</a> 7. <a href="https://www.safeworkaustralia.gov.au/statistics-and-research/cost-injury-and-illness-occupation">https://www.safeworkaustralia.gov.au/statistics-and-research/cost-injury-and-illness-occupation</a> 8. <a href="https://www.aihw.gov.au/reports/health-welfare-expenditure/disease-expenditure-australia/data">https://www.aihw.gov.au/reports/health-welfare-expenditure/disease-expenditure-australia/data</a></div>		



## What are injuries?

The Strategy adopts the Aboriginal and Torres Strait Islander holistic view of health.<sup>8</sup> Injuries are not just the physical harm caused by an external event, but the spiritual, emotional and cultural aspects of harm.<sup>9</sup> This means that injury prevention should focus not only on reduced hospital bed days or lives lost, but also the safety and emotional wellbeing of individuals as well as the whole community.

The Strategy addresses these broadest definitions of injuries – the physical, cultural, spiritual and community cost of injuries. It addresses **intentional injuries**, including violence and intentional self-harm (suicide and self-inflicted injury) and **unintentional injuries**, including road traffic injuries, falls, sports injuries, poisoning, drowning and burns. It should be noted that many of these latter types of injuries can also be the result of intended harm.

## Injuries are preventable

Although commonly regarded as random and inescapable events, increased knowledge around the mechanisms by which injuries can occur has led to the understanding that injuries can be prevented.

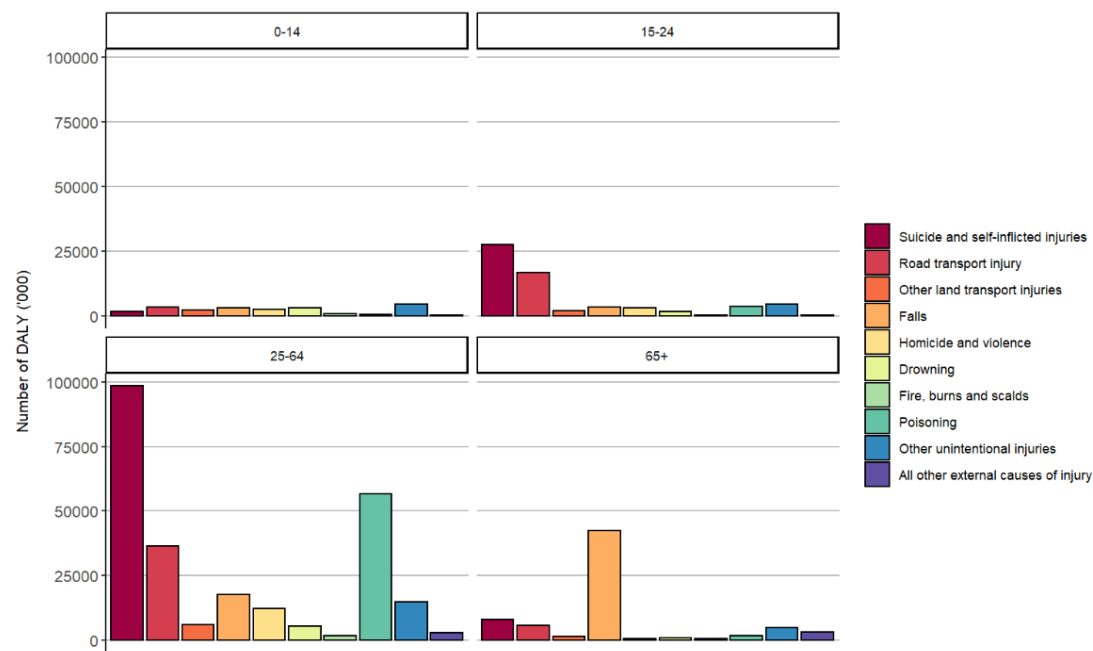
This also extends to the ability to prevent spiritual, emotional and cultural injury through the identification of causes and removing or reducing this exposure.

Table 1. Leading causes of burden of injury based on Disability Adjusted Life Years (DALYs) as derived from ICD-coded external cause data (2015)<sup>[1]</sup>

Rank	Overall	0-14 years	15-24 years	25-64 years	65+ years
1	Suicide and self-inflicted injuries	Other unintentional injuries	Suicide and self-inflicted injuries	Suicide and self-inflicted injuries	Falls
2	Falls	Road transport injury	Road transport injury	Poisoning	Suicide and self-inflicted injuries
3	Poisoning	Falls	Other unintentional injuries	Road transport injury	Road transport injury
4	Road transport injury	Drowning	Poisoning	Falls	Other unintentional injuries
5	Other unintentional injuries	Homicide and violence	Falls	Other unintentional injuries	All other external causes of injury
6	Homicide and violence	Other land transport injuries	Homicide and violence	Homicide and violence	Poisoning
7	Other land transport injuries	Suicide and self-inflicted injuries	Other land transport injuries	Other land transport injuries	Other land transport injuries
8	Drowning	Fire, burns and scalds	Drowning	Drowning	Drowning
9	All other external causes of injury	Poisoning	Fire, burns and scalds	All other external causes of injury	Fire, burns and scalds
10	Fire, burns and scalds	All other external causes of injury	All other external causes of injury	Fire, burns and scalds	Homicide and violence

<sup>1</sup>AIHW. Analysis of burden of disease database. 2015.

<sup>[1]</sup> This table is based on ICD-coded data from death registries and hospital admissions, identified on the basis of external causes codes only. It is important to recognise that injuries directly linked to specific settings or types of activity (such as most sports and leisure related injuries, as well as those that are work-related), are not able to be explicitly identified from external causes alone. To identify those, there is a need to also look at Activity codes from the ICD External Causes chapter.<sup>10</sup> DALYs measure burden by combining years of living with a disability and years of lives lost.

Figure 2. Injury cause by DALYs for each age group<sup>[2]</sup>

AIHW 2015<sup>1</sup>. Analysis of burden of disease database.

The Strategy uses routinely collected and available data on the burden of injury, death and hospital admissions. Data were obtained from the Australian Institute of Health and Welfare (AIHW) Australian Burden of Disease Study 2015 dataset<sup>1</sup> to identify the leading types of injury in Australia. The most recent data describing the overall burden of injury among Aboriginal and Torres Strait Islander people are from the 2011 Australian Burden of Disease Study dataset. The datasets include causes such as: intentional self-harm, road traffic injuries, falls, violence, poisoning, drowning, burns and other injuries. The Strategy recognises that the rank order and magnitude of these events change over different life-stages and in the priority population groups.

It is important to note that this 'fatal and hospitalised injury' approach does not clearly reflect the injury burden that results from key activities such as workplace or sports injury. The Strategy recognises the significant burden of injury stemming from both workplace and sports activities and that burden is reflected in the injury prevention objectives across the life-stages.<sup>6, 7</sup>

The recommended actions are a combination of measures that address injuries of the greatest burden, for which we have evidence of proven or promising strategies or where there is relative ease and acceptability of action.

<sup>[2]</sup> These data are presented according to external cause of injury codes. When data are also analysed by activity code, it can be identified that many of the cases associated with several of the categories shown above, are related to activities that are directly associated with sport or workplace settings.

## Where are we up to?

*Injury is the fifth leading health condition contributing to the burden of disease, accounting for 9% of all Disability Adjusted Life Years (DALY) in Australia.<sup>11</sup>*

*The leading causes of injury burden are suicide/ self-inflicted injuries (33%), falls (16%), poisonings (15%) and road transport injury (15%).<sup>1</sup>*

*Age-standardised rate (ASR) of the DALY from injury are nearly three times higher for Aboriginal and Torres Strait Islander people than the rate for other Australians (49.9 per 1,000 population compared to 16.6 in other Australians).<sup>12</sup>*

*Injury is a leading cause of death and hospitalisation for children and young people in Australia.<sup>13</sup>*

While there are other broad groups, such as heart disease and cancer, which pose a greater burden, there is no greater cause of loss of life to those aged 1 to 44 years than injury.<sup>2</sup>

The burden of injury, of course, goes well beyond the death and hospital admission statistics. Loss of income, reduced quality of life, post-traumatic stress, and the emotional impact of grief on families, are a few of the additional burden of injuries that are less well measured. There is a high frequency of injuries that are treated outside of hospital settings. For example, musculoskeletal injuries related to sports or workplace injury, can have high treatment costs, loss of productivity and can also lead to permanent physical impairment and impact on activities of daily living or quality of life.

Over recent decades, changing injury data indicate some 'wins' in terms of significant reductions and some 'losses'. These vary by age group, injury cause, population group and injury severity.

- In 2004-05 the age-standardised rate of injury deaths was 47.2 deaths per 100,000, a reduction from 55.4 deaths per 100,000 in 1999-00. However, there has been little change since then.<sup>4</sup> Further, the age-standardised rate of injury hospitalisations increased between 2007-08 and 2016-17 by an average of 1.2% per year (1,849 cases per 100,000 population in 2007-08 to 2,051 per 100,000 in 2016-17).<sup>5</sup>
- Injuries are not spread evenly across the population. Among Aboriginal and Torres Strait Islander people, while the overall burden of disease dropped between 2003 and 2011, the burden from injury increased. There have been some improvements over that time, such as a reduction, by 3%, of transport-related deaths among Aboriginal and Torres Strait Islander people, between 2001-2002 and 2014-2015. However this has occurred alongside increases in many other injury causes, including poisoning, which increased by 6.4% per year.<sup>2</sup>
- Overall, between 1999-00 and 2016-17, transport-related deaths were reduced by an average of 3.7% each year, drowning by 2.6%, and homicide by 2.3%.<sup>4</sup> Data also show significant decreases in the rate of hospitalised injury cases from accidental drowning and submersion (2.2% decrease per year from 2007-08); accidental poisoning (1.0% decrease per year from 2007-08); thermal causes of injury (1.5% decrease per year from 2007-08) and assault (3.2% decrease per year from 2007-08).<sup>5</sup>

These successes may reflect the investment in research, policy and action in these areas. Taking transport injuries as an example, there is considerable evidence that investment in safer vehicles and safer roads, combined with legislation and education to encourage safer road user behaviour, is responsible for much of these gains.

While there are many challenges in preventing injury-related harm, there is also widespread commitment to action, a strong research base, and many examples of good practice at community, state and territory and national levels.

### 3. Vision

The overall vision of the Strategy is to:

***Reduce the overall burden of injury in Australia and address inequities that contribute to the disproportionate burden of injury experienced by specific population groups***

Three core outcome indicators reflect the Strategy's Vision:

- 1) Reduced rates of injury in key priority areas  
**Target:** To reduce the overall rate of injury burden by 30%.
- 2) Reduced burden of injury in priority populations  
**Target:** To reduce the overall rate of injury by 40% among the priority populations.
- 3) Reduced risk of injury due to the three cross-cutting priority areas.

### 4. Call for action

Injury has a significant impact on Australians. There is a need to strengthen Australia's response to injury to benefit everyone. Everyone has a role to play in injury prevention. Coordinated action across many and varied departments and agencies is needed for lasting and effective change. The settings, risk factors and repercussions of injuries cut across many sectors: health, transport, housing, urban planning, environment, work health and safety, social services, education, policing and justice departments and agencies. This coordination and engagement should occur at the national, state and local levels if Australia is to effectively reduce and prevent injury. Investments must be culturally appropriate, build on available evidence and tailored to local contexts and settings.

### Principles

Six principles underpin the Strategy and should be at the forefront in planning and implementing the Objectives and Actions in this Strategy. The recommended infrastructure needed to enable these principles is outlined in [Section 12. Making Progress](#).

Principle in action	How is this implemented?
<b>Evidence-based</b>	<ul style="list-style-type: none"> <li>• Address priority areas through data-driven and evidence-based action.</li> <li>• Focus first on injuries which, for any life-stage, represent the greatest burden (as measured by overall burden, fatalities and hospital admissions), and employ strategies for which there is evidence of their effectiveness.</li> <li>• When data or evidence are lacking, utilise the opinion of relevant experts.</li> </ul>
<b>Equity</b>	<ul style="list-style-type: none"> <li>• Provide equitable access to information and education, products, environments, programs and policies that protect and reduce the risk of serious injury.</li> <li>• Ensure that information is tailored to different needs including culture, race, age, gender identity, sexual orientation, socio-economic standing and geographic location.</li> <li>• Develop programs and policies to address the social and cultural determinants of health.</li> </ul>

Principle in action	How is this implemented?
	<ul style="list-style-type: none"> <li>Plan programs to address the overrepresentation of people most at risk of injury, recognising that risks differ according to people's conditions. For example the dynamics of the injury process can differ among people living with a disability where the condition magnifies or alters the impact of injury.<sup>14</sup></li> </ul>
<b>Engagement</b>	<ul style="list-style-type: none"> <li>Engage, empower and enable Aboriginal and Torres Strait Islander communities to co-design and implement programs and influence policies which are in keeping with the priorities of their local communities.</li> <li>Engage with groups most impacted by injury, those affected by the proposed actions and key community groups to ensure that all initiatives are culturally safe.</li> <li>Build on what has already been achieved within a community, and work with local people to plan and deliver initiatives to reduce injuries.</li> </ul>
<b>Coordination</b>	<ul style="list-style-type: none"> <li>Ensure efforts are coordinated between partner agencies, with clear lines of responsibility and unified leadership.</li> <li>Build clear and ongoing communication between all partners.</li> <li>Ensure actions complement relevant Australian strategies and plans.</li> </ul>
<b>Resourcing</b>	<ul style="list-style-type: none"> <li>Target funding and action to reduce the burden of injury.</li> <li>Identify priority areas for action, which are achievable, acceptable and modifiable.</li> </ul>
<b>Responsibility</b>	<ul style="list-style-type: none"> <li>Ensure each lead agency remains accountable to that action.</li> <li>Adopt a clear communication plan with all partners and articulate deliverables.</li> </ul>

**Case study: Royal Life Saving**

- To provide an example of an NGO that coordinates well at a national level.

**Case Study: QLD coordination for injury prevention**

- To provide an example of independent leadership and collaboration between injury prevention stakeholders within one jurisdiction

**Case study: State based Health Department**

- To provide an example of a state government Health department working with key injury stakeholders and the positive impacts of resourcing injury prevention

## 5. Priority populations

Injuries disproportionately affect population groups. As such, injury prevention priorities and actions should recognise those inequities and, where possible, address the underlying social and cultural determinants.

The Strategy identifies priority populations, for which there is growing evidence of inequities which result in their overrepresentation among fatal and serious injuries:

- **Aboriginal and Torres Strait Islander people**
- **People living in rural and remote areas**
- **People experiencing socio-economic disadvantage**

Policy makers and community planners are encouraged to provide individuals who experience the most disadvantage with equitable opportunities for education, employment, income, and affordable housing. Reducing socio-economic inequities will reduce unfair and unequal distribution of injuries in society. Policy makers and community planners should also be mindful that broad population initiatives prioritise key population groups, such as Aboriginal and Torres Strait Islander people, through meaningful engagement and partnerships and by ensuring equitable access to culturally appropriate programs.

The intersectionality of injury experienced by people in the priority populations must be considered. This means that there is considerable overlap across the priority population groups. For example, Aboriginal and Torres Strait Islander people are overrepresented in both rural and remote populations and among people experiencing socio-economic disadvantage. Priorities and actions, therefore, will often cut across all groups.

### Aboriginal and Torres Strait Islander people

#### Understanding context

Aboriginal and Torres Strait Islander peoples are the oldest living cultures globally. For this survival to occur, community, spiritual and cultural strengths and connectedness continue. These include and incorporate aspirations, personal wellness, positive self-image, self-efficacy, non-familial connectedness, family connectedness, positive opportunities, positive social norms and cultural connectedness.<sup>15</sup>

However, to fully understand the extent of injury among Aboriginal and Torres Strait Islander peoples, the impact of colonisation must be acknowledged. Aboriginal and Torres Strait Islander communities continue to experience the devastating impacts of colonisation including: socioeconomic disadvantage, the impact of institutionalised and systemic racism, too few culturally appropriate services, limited access to services including health and housing, disruption to culture, ongoing family removal and separation. All of which have contributed to intergenerational trauma.

Intergenerational trauma and consideration of the complex issues around it, must be considered in injury prevention planning for Aboriginal and Torres Strait Islander people. “Trauma informed” models of service delivery are particularly appropriate for Aboriginal people experiencing the impacts of violence and intergenerational trauma.

Trauma informed services <sup>[3]</sup> are underpinned by knowledge around trauma and the impact on how individuals receive services. These services look at all aspects of their operations (including service, management and program delivery) from a trauma lens.<sup>16</sup> Importantly, injury prevention programs and initiatives should be culturally safe and privilege Aboriginal and Torres Strait Islander ways of knowing, being and doing.<sup>17</sup>

### Burden of injury

Aboriginal and Torres Strait Islander people experience an inequitable burden of injury. The rates of injury for key causes can be many times those of other Australians.<sup>18</sup>

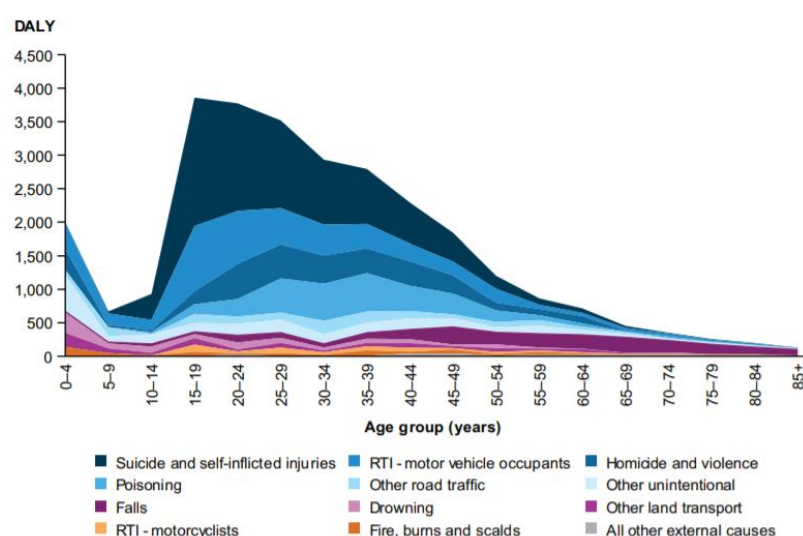
- Overall, Aboriginal and Torres Strait Islander Australians experience rates of injury three times higher than non-Indigenous Australians (49.9 per 1,000 population compared to 16.6 in non-Indigenous Australians).<sup>12</sup>
- Injuries are responsible for 14% of the overall gap between Aboriginal and Torres Strait Islander people and other Australians.<sup>12</sup>
- Suicide accounts for 30% of the total burden of injury for Aboriginal and Torres Strait Islander people across all age groups, followed by road traffic injury of motor vehicle occupants (16.5%) and homicide and violence (12%)<sup>12</sup> (Figure 3).
- The leading causes of *hospitalised* injuries is assault and falls while the leading cause of injury-related *deaths* is intentional self-harm (33% of all injury deaths) followed by transport crashes (20% of all injury deaths) and unintentional poisoning (14% of all injury deaths). Other frequent causes of deaths were homicide and falls.<sup>19</sup>
- The burden of injury experienced by Aboriginal and Torres Strait Islander people is particularly high for those living in remote areas,<sup>18</sup> with rates of death much higher in remote and very remote areas compared to major cities.<sup>19</sup>
- Almost half of all Aboriginal and Torres Strait Islander injury hospitalisations live in the most disadvantaged socioeconomic areas.<sup>20</sup> It should be noted however that the majority of Aboriginal and Torres Strait Islanders reside in urban and regional areas<sup>21</sup> and that these differences largely reflect the uneven distribution of Aboriginal and Torres Strait Islander people across socioeconomic areas.<sup>20</sup>

It is also important to note there are data limitations. For example, there are no data to date, that assess the risk and impact of injury among Aboriginal and Torres Strait Islander people living with a disability. Similarly, there is a lack of timely injury data that provide sufficient detail and granularity to inform individual communities' injury prevention priorities.

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<sup>[3]</sup> See also Atkinson, J., Nelson, J., Brooks, R., Atkinson, C. & Ryan, K. Addressing Individual and Community Transgenerational Trauma. In: Dudgeon P, Milroy M & R, W. (eds.) *Working Together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* and Aboriginal and Torres Strait Islander Healing Foundation Development Team. 2016. Restoring our spirits, reshaping our lives: Creating a trauma aware, healing-informed response to the impacts of Institutional child sexual abuse for Aboriginal and Torres Strait Islander peoples (Discussion paper). Available: [http://www.healthinonet.ecu.edu.au/uploads/resources/31872\\_31872.pdf](http://www.healthinonet.ecu.edu.au/uploads/resources/31872_31872.pdf)

Figure 3. External cause of injury burden (DALY) by age and external cause, Indigenous Australians, 2011



AIHW 2016<sup>12</sup>. Figure 10.2.2, pg 152

## Applying the Strategy principles for Aboriginal and Torres Strait Islander people

### Aboriginal Community Controlled Health Organisation (ACCHO) collaboration

The policy commitment to self-determination for Indigenous Australians has resulted in the establishment of many Aboriginal Community-Controlled Health Organisations (ACCHOs) and Aboriginal Community Controlled Organisations (ACCOs). There is opportunity for significant engagement with these organisations to build on the evidence for injury causation and prevention. ACCHO's are uniquely placed to consider injury in the context of the whole of person. They work from a strengths-based approach with a foundation of trust and create a flow between acute injury management and planned injury prevention. Key to this strategy is the support of ACCHOs in leading injury prevention and embedding within their comprehensive primary health care service delivery model.

Additionally, core principles must be adhered to when developing, implementing and evaluating programs aimed at enhancing safety and social and emotional wellbeing and reducing injury among Aboriginal and Torres Strait Islander people. These principles are core to all appropriate frameworks, strategies and guidelines. Of prime importance is the centrality of culture and commitment to the cultural determinants of health (language, knowledge and beliefs, kinship, cultural expression, self-determination, and country and caring for country).

Principle in action	What does this mean for Aboriginal and Torres Strait Islander people?
<b>Evidence-based</b>	<ul style="list-style-type: none"> <li>Improve the quality and availability of timely Aboriginal and Torres Strait Islander injury data in routine collection.</li> <li>Invest in high priority research in injury prevention.</li> <li>Support the scaling up and transferability of local level interventions known and successful interventions.</li> <li>Develop an Aboriginal and Torres Strait Islander monitoring and evaluation strategy as part of the implementation of this Strategy.</li> </ul>
<b>Equity</b>	<ul style="list-style-type: none"> <li>Develop capability within the Aboriginal and Torres Strait Islander workforce so that Indigenous injury is adequately identified and managed.</li> <li>Ensure an equitable approach to injury prevention including the prioritisation of Aboriginal and Torres Strait funding to address current disparities.</li> </ul>



Principle in action	What does this mean for Aboriginal and Torres Strait Islander people?
<b>Engagement</b>	<ul style="list-style-type: none"> <li>• Support Aboriginal and Torres Strait Islander health organisations with information and strategies to identify local level strategies.</li> <li>• Build health literacy in communities through targeted interventions.</li> </ul>
<b>Coordination</b>	<ul style="list-style-type: none"> <li>• Ensure a coordinated effort across the government sector, the Aboriginal and Torres Strait Islander community-controlled sector and other non-profit organisations to address injury prevention.</li> <li>• Support advocacy for injury prevention across other sectors that influence the social determinants of injury outcomes.</li> <li>• Promote multi-sectoral collaboration to address the links between injury and mental health, drug and alcohol and substance misuse and excess morbidity and mortality.</li> </ul>
<b>Resourcing</b>	<ul style="list-style-type: none"> <li>• Ensure current Aboriginal and Torres Strait Islander injury prevention resources are used in the most efficient and effective manner.</li> <li>• Invest to fill evidence gaps in Aboriginal and Torres Strait Islander injury.</li> <li>• Invest in infrastructure and provide funding for communities to support sustainable local level strategies.</li> </ul>
<b>Responsibility</b>	<ul style="list-style-type: none"> <li>• Provide leadership in ensuring advocacy across all portfolios with responsibility for Injury prevention.</li> <li>• Promote state, territory and Commonwealth coordination and collaboration across all relevant portfolios with responsibility for Injury Prevention.</li> </ul>

### Working appropriately with Aboriginal and Torres Strait Islander people, communities and organisations

There are several guidelines to advise organisations how to work appropriately with Aboriginal and Torres Strait Islander people, communities and organisations. For example, the *Active and Safe: Aboriginal child injury prevention guidelines*<sup>22</sup> state that:

- Known effective programs need to be contextualised and localised for the intended community;
- Programs should build on strengths and promote resilience; and
- Community-based programs should be prioritised.

Programs most likely to be successful are community-led and owned, and include integrated services coordinated effectively with the community. Additionally, the program should be tailored to meet the needs and support the strengths of the community. The guidelines recognise that many injury prevention efforts also need to address the underlying social and cultural determinants of Aboriginal and Torres Strait Islander health and be evaluated appropriately.

**Case study:** The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (the Centre) aims to reduce the causes, prevalence and impact of suicide on Indigenous individuals, families and communities.

The Centre highlights 14 key areas that suicide prevention programs and services follow to be considered best practice. These 14 areas, outlined below, fall under the pillars of cultural and community focus, strengthening Indigenous governance and cultural respect<sup>23</sup>:

#### Cultural and Community Focus

1. Are concerned with reconnection and community life,
2. Are concerned with restoration and community resilience,
3. Are a means of empowering people to regain a sense of control and mastery over their lives,

4. Have a focus on social and emotional wellbeing and mental health promotion, rather than solely focusing on mental illness and suicide,
5. Have a focus on recovery and healing from stress and trauma,
6. Reflect Aboriginal and Torres Strait Islander understandings of health, mental health and suicidal behaviours.

#### **Strengthening Indigenous Governance**

7. Have strategies that are Indigenous-led, family focused, culturally responsive, and context specific,
8. Are concerned with self-determination and community governance,
9. Include activities that use culturally responsive techniques and methods and processes,
10. Use interdisciplinary approaches that provide outreach services,
11. Value and enact partnerships with Aboriginal Community Controlled Health Services facilitate ownership and involvement from local communities,
12. Involve Indigenous people in all stages of consultation, negotiation and decision-making processes to establish community ownership of suicide prevention activities and other initiatives.

#### **Cultural Respect**

13. Recognise and harness the broad range of skills and expertise of Aboriginal and Torres Strait Islander people, to improve health and wellbeing and reduce suicidal behaviours
14. Ensure that organisations and staff are culturally competent and that services are developed and delivered in culturally safe and responsive manner.<sup>23</sup>

In addition to these principles, the Centre's Evaluation Framework provides key indicators which services can use to develop and assess programs.<sup>23</sup> Lessons learned from The Centre can be translated to reflect best practice across other injury prevention programs, beyond suicide prevention.

#### **Case study:** Example of Aboriginal and Torres Strait Islander program

- To describe a safely program which includes educational resources, training of health and education workers, provision of low costs seats and free fitting.

## **Rural and remote populations**

### **Background**

There are many unique aspects of living in rural and remote areas of Australia. From life being inextricably connected with the land and climate; the challenges of distances or access to services; the potential for both greater community connectedness and social isolation; and overall, reduced opportunities for employment and advanced education and training.

As key social determinants of health, these aspects of life mean that, compared with people living in metropolitan areas, people in rural and remote areas, have many indicators of poorer health. Rural and remote populations also have reduced access to, and use of, primary health care services, higher rates of diseases and injuries, and thus higher rates of hospitalisations and mortality<sup>24</sup>

Linked with this challenging geographical and socio-economic environment, people who live in rural and remote areas have higher levels of health risk behaviours (such as tobacco and alcohol consumption). They are also exposed to greater physical environmental risks, such as the roads on which they travel, the houses in which they live and the occupations in which they work.

Furthermore, the challenges of access to mental health care and primary health care services, contribute to poorer health outcomes and reduced life expectancy for people living in rural and remote areas.<sup>25</sup> While there are opportunities to improve access to health information and services through the internet and tele-health services<sup>26</sup> an aging population and climate change are expected to increase the vulnerability of rural and remote populations.<sup>27</sup>

## Burden of injury

Injury rates are higher the further people live from major centres<sup>28</sup> (See Figure 4).

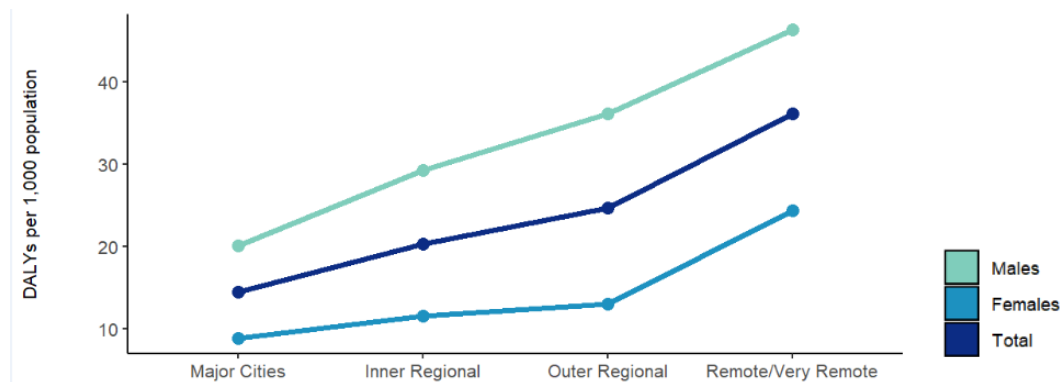
- The rate of injury in remote and very remote areas in Australia is 2.5 times higher than people living in major cities.<sup>29</sup>
- The main causes of injury for this group are suicide and other self-inflicted injuries, followed by road traffic injury, poisoning and falls.<sup>29</sup>
- People living in rural and remote areas were 1.4 times more likely to have experienced partner violence (from the age of 15 years) compared to those living in major cities.<sup>30</sup>

Several factors contribute to the elevated burden of injury of people living in rural and remote areas including: higher road speeds, lower levels of health literacy linked with lower education and employment levels, as well as greater distances to definitive trauma care.

In the sports context, it has also been suggested that people in rural and remote communities might also be disadvantaged through exposure to different hazards and risks, due to differences in the quality, maintenance and availability of high-quality sporting facilities.<sup>31</sup>

Those living in rural and remote Australia are more vulnerable to injury from specific causes such as the health impacts of extreme weather events. Injury risk is compounded when this is combined with other risk factors, such as pre-existing health conditions, lower socio-economic status, poorer housing and the surrounding infrastructure (e.g. communications, transport, water and sanitation), increased risk exposure linked with many rural livelihoods; and access to health services.<sup>32</sup>

Figure 4. Injury DALYs per 1000 population by geographic area



AIHW 2015<sup>1</sup>. Analysis of burden of disease database.

### Case study: Rural and remote

- To provide an example of a road safety program that has been effective in rural and remote areas of Australia

## Socio-economically disadvantaged people

### Background

Australia is no exception when it comes to the fact that globally, people in the lower socio-economic levels of society have higher rates of illness and injury, and shorter life expectancy.<sup>33</sup> There are multiple factors associated with these health statistics, including reduced access to safer and healthy housing, lower levels of health literacy and associated increase in risky health behaviours such as smoking, consumption of harmful levels of alcohol, less safe environments such as older cars, and jobs that carry greater exposure to health and safety risks.<sup>33</sup>

A snapshot of health in Australia in 2018 indicated that compared to people in the highest socio-economic quintile, those in the lowest quintile were 2.7 times more like to smoke tobacco daily, and 1.6 times more likely to be inactive or insufficiently active.<sup>34</sup>

The association between low socio-economic means and mental health is equally strong. One in four Australians who are among the poorest SES quintile have high or very high indicators of psychological distress compared to 1 in 20 people in the richest quintile.<sup>35</sup> Risk factors for psychological distress and mental disorders include homelessness, unemployment, violence and crime – to which people in lower SES areas are vulnerable. Poor communities also tend to have far worse consequences of mental disorders than more likely to experience or be exposed.<sup>36</sup>

It is vital that investment in injury prevention focus on the most socio-economically disadvantaged people.

### Burden of injury

There is a strong association between socioeconomic disadvantage and injury. This is most evident for transport crash deaths, unintentional poisoning deaths and male suicide deaths.<sup>37</sup>

This Strategy encourages policies, programs and research to prioritise the most socio-economically disadvantaged people to address health inequities that influence increased injury. Disadvantage is associated with lower levels of education and employment, poorer housing standards and ownership of older motor vehicles.<sup>38</sup> These factors increase the risk of an injury event and reduce the likelihood of access to health information and health services. Higher rates of hospitalised injury were associated with the lowest SES group (most disadvantaged).<sup>20</sup>

Data from the AIHW indicate that in 2015, the rate of injury in the lowest socio-economic group in Australia was 1.8 times higher than the highest socio-economic group.<sup>39</sup> The main causes of injury for this group are suicide and self-inflicted injuries, followed by poisoning, road traffic injury, and falls.<sup>39</sup> People from socio-economically disadvantaged areas are 1.5 times more likely to experience partner violence compared to those living in areas with the least disadvantage.<sup>40</sup>

*Table 2. Summary of injury mortality trends (rates over time for selected external causes), by 2 categories of socioeconomic status of area of usual residence, Australia, 2009–10 to 2015–16*

Cause	Lowest SES group (most disadvantaged)	Highest SES group (least disadvantaged)
All injury	Increasing	Staying the same
Transport crash	Decreasing	Decreasing
Drowning	Decreasing	Staying the same
Unintentional poisoning	Increasing	Staying the same
Falls	Staying the same	Increasing
Thermal causes	Staying the same	Staying the same
Suicide	Increasing*	Staying the same
Homicide	Staying the same	Staying the same

\*Significant increase identified in Suicide deaths rates for those aged 25–44 in the most disadvantaged group

AIHW 2019<sup>37</sup>. Table S1, pg v

### Priority areas for action across the priority population groups

While acknowledging that all priority actions across the life stages are relevant for each of the priority populations, the following table (page 17) lists those Priorities that specifically target these population groups and reflect either where the burden is greatest or the strongest evidence of effective prevention strategies exist.

Table 3 Priority areas for action across the priority population groups

Injury type Life stage(s)	Objectives		Priority populations' specific partner agencies		
			Aboriginal	Rural + remote	Low SES
<b>Intentional self-harm</b>	<b>1. Reduce the rate of intentional self-harm</b>		✓	✓	✓
	<b>2. Reduce the rate of intentional self-harm among Aboriginal and Torres Strait Islander people</b>		✓		
Youth Adult Older adults	Lead agency (partners)	National, state and territory departments of health (mental health services), Justice and youth affairs, Department of Veterans' Affairs (State and territory departments of Education, National Mental Health Commission, local government, AOD council of Australia, AOD information and treatment services, Family Mental Health Support Service, youth focused not-for-profit organisations, local health districts, Australian Government Office for Youth, NGOs with a core focus on older people, schools and tertiary education providers, community mental health providers, peer workers, Royal Australasian College of General Practitioners)	ACCOS, ACCHOs, NIAA	PHNs, rural mental health primary healthcare, education providers	mental health primary healthcare, mental health NGOs, education providers
<b>Falls</b>	<b>3. Reduce the rate of falls</b>		✓	✓	✓
Babies+children Older adults	Lead agency (partners)	Department of Health, State and territory departments of health, state and territory departments of infrastructure and planning, Department of Veterans' affairs (Local government, strata management bodies, Kidsafe, housing provider services, aged care services, Commission on Safety and Quality in Health Care, NGOs with a core focus on children or older people)	ACCOS, ACCHOs	Local gov, rural primary healthcare workforce	Primary healthcare workforce
<b>Poisoning</b>	<b>5. Reduce the rate of drug-related poisoning</b>			✓	✓
Adults	Lead agency (partners)	Department of Health (State and territory departments of health, PHNs, mental health service providers, NGOs, alcohol and other drug services, general practitioners, Aboriginal Community Controlled Organisations)		Mental health service providers	AOD services
<b>Road + land transport</b>	<b>6. Reduce road-related injury</b>		✓	✓	✓
	<b>7. Increase child pedestrian safety</b>			✓	✓
	<b>8. Promote the correct use of appropriate child car seats</b>		✓	✓	✓
Babies+children Youth Adults Older adults	Lead agency (partners)	State and territory departments of transport and roads (State and territory departments of infrastructure, cities and regional development and health, Police, NGOs with a core focus on young people, alcohol and other drug council of Australia, AOD information and treatment services, youth focused not-for-profit organisations, National Drug Driving Working Group, PHNs)	ACCOS, ACCHOs	Rural Health Services	Social services
<b>Homicide and violence</b>	<b>10. Increase primary prevention of violence and equitable access to timely, appropriate and affordable care</b>		✓		
	<b>11. Reduced the prevalence and impact of violence</b>		✓		
Babies+children Adults Older adults	Lead agency (partners)	State and territory departments of health (State and territory Departments of Education, primary healthcare, schools, Department of Social Services, Local government, Kidsafe, ECHC, primary healthcare, NGOs with a focus on women's health and safety, antenatal educators, police, residential care facilities)	ACCOS, ACCHOs		
<b>Drowning</b>	<b>13. Reduce drowning and near-drowning events</b>		✓		
Babies+children Across the population	Lead agency (partners)	State and territory departments of health and road and marine departments (Local government, state and territory departments of sport and recreation, Kidsafe, Royal Life Saving, Australian Water Safety Council, and education departments FarmSafe, rural health services, police)	ACCOS, ACCHOs		

<b>Sport</b>	<b>16. Reduce the rate and impact of sports injuries</b>	✓
Babies+children Youth	Lead agency (partners) Sports Australia and peak sports bodies (Sporting associations, brain injury NGOs, Australian Institute of Sport, medical practitioners, coaching groups, local government, Sport and Recreation and Education state and territory departments, Department of Defence, peak sports bodies and sports medicine authorities, sporting associations, schools)	ACCOS
<b>Determinants of injury</b>	<b>17. Increase the proportion of families accessing services relevant to the first 2000 days of life.</b>	✓
	<b>18. Increase proportion of children living in supportive home environments</b>	✓
	<b>19. Prioritise the availability of and access to culturally appropriate programs and services</b>	✓
	<b>20. Reduce the use of alcohol, and related harms of alcohol, during pregnancy</b>	✓
Babies+children Youth Adults Older adults Across the population	Lead agency (partners) National, state and territory departments of departments of health, social services, and education (Health, Education, National Mental Health Commission, Family and Community Services, Housing, PHNs, local health districts, Early Childhood Education and Care Centres, Primary Health Care Services, Health Organisations, NOFASD, FASD Hub, FASD Diagnostic Services)	ACCOS, ACCHOs, NIAA
<b>Alcohol</b>	<b>22. Reduce alcohol-related harm</b>	✓
Across the population	Lead agency (partners) State and territory departments of health (State and territory departments of education, police, community organisations, PHNs, health districts, AOD information and treatment services, sporting peak organisation and bodies)	ACCOS, ACCHOs

## 6. Babies and children (0-14 years)

Injuries are the leading cause of death, disability and hospitalisation among babies and children.<sup>11</sup> The burden of injury increases as children age, except for children aged 5-9 years (see Table 2). From 2001-2012, child injury hospitalisation rates did not change, with the annual cost of child injury hospitalisations estimated at \$212 million over that period.<sup>13</sup> Further, for every child hospitalised with a serious injury, another 13 children are hospitalised with minor injuries.<sup>13</sup>

Early life experiences play an important role in the development of physical, cognitive, social and emotional health.<sup>41, 42</sup> Factors such as, pre-natal exposure to alcohol and the physical and socio-cultural environment the child is born into can influence the child's later risk of intentional and unintentional injuries. Consequently, it is important to reduce exposure to the risk factors for injury that are set in motion in early childhood such as neglect, abuse, and stress.

Policy makers and community planners are encouraged to prioritise programs which reduce these risk factors in early childhood. Frameworks such as the 'First 1000 days'<sup>43</sup> and the First 2000 days'<sup>41</sup> highlight the role of positive early life (beginning from conception) and its role in shaping health and wellbeing over the lifespan.

Table 2. Burden of injury <sup>[4]</sup> (DALYs) for children and young people aged up to 14 years

Rank	<1 year	1-4 years	5-9 years	10-14 years
1	Other unintentional injuries	Drowning	Falls	Suicide and self-inflicted injuries
2	Homicide and violence	Other unintentional injuries	Other unintentional injuries	Falls
3	Road transport injury	Homicide and violence	Road transport injury	Road transport injury
4	Drowning	Road transport injury	Drowning	Other unintentional injuries
5	Falls	Other land transport injuries	Other land transport injuries	Other land transport injuries
6	Other land transport injuries	Falls	Homicide and violence	Homicide and violence
7	Fire, burns and scalds	Fire, burns and scalds	Fire, burns and scalds	Poisoning
8	Poisoning	Poisoning	Poisoning	Fire, burns and scalds
9	All other external causes of injury	All other external causes of injury	All other external causes of injury	All other external causes of injury
10	-	-	-	Drowning
<b>Total Disability Adjusted Life Years</b>				
	2509	6904	4825	7014

AIHW 2015<sup>1</sup>. Analysis of burden of disease database.

There is a gap in data relevant to the burden of injury during the antenatal period. However, in the absence of such data, key areas and their potential long-term impact should nevertheless be considered in the prevention of lifetime injury. As a child with Fetal Alcohol Spectrum Disorder (FASD) is more likely to experience risk factors associated with increased risk of injury throughout their life, it is important to prevent the occurrence of FASD and if present, minimise its impact. FASD

<sup>[4]</sup> It is also important to acknowledge that these burden of injury data do not capture the importance of sport and recreation settings to injury risks and rates; these risks can be assessed through exploration of activity codes.<sup>6, 44</sup>

affects many communities – it is not isolated to a specific region or population group. Aboriginal and Torres Strait Islander communities, while experiencing high rates of FASD (ranging from 1.87 to 4.7 per 1000 births),<sup>45</sup> have shown leadership in addressing this issue.<sup>46</sup> The Minister for Health has also supported work to address FASD, with priority funding associated with the National FASD Strategic Action Plan.<sup>45</sup>

## Priority areas for action

Burns	<b>Objective 14</b>	<b>Reduce the rate of scalds and burns to infants and toddlers</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Support programs that provide subsidised safety equipment (such as thermostatic mixing valves, stove guards, smoke detectors) to socio-economically disadvantaged groups.</li> <li>b) Raise awareness of key burns and scalds hazards in the homes, prevention measures and first aid treatment.</li> </ul>
	<i>Lead agency (partners)</i>	<i>State and territory departments of health (Local government, preschools, Kidsafe, Australia &amp; New Zealand Burn Association, plumbers, electricians, retailers of safety equipment)</i>
Drowning	<b>Objective 13</b>	<b>Reduce drowning and near-drowning events among children</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Promote water safety skills programs for children under 5 years of age, and, provision of water safety education for children 5-14 years.</li> <li>b) Increase access to water safety programs for all children living in rural and remote areas.</li> <li>c) Strengthen compliance with pool fencing safety regulations by local government.</li> <li>d) Raise awareness among families living in rural and remote areas of the proven value of installing child proof fences around gardens and play areas that are within 'wandering distance' of creeks and dams.</li> </ul>
	<i>Lead agency (partners)</i>	<i>State and territory departments of health (Local government, state and territory departments of sport and recreation, Kidsafe, Royal Life Saving, Australian Water Safety Council, and education departments Aboriginal Community Controlled Organisations, FarmSafe, rural health services)</i>
Falls	<b>Objective 3</b>	<b>Reduce the rate of falls</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Provide home safety education (parent education and training/counselling during health and wellness home visits, hazard checklists) with subsidised access to stair guards, table corner coverings for socio-economically disadvantaged groups.</li> <li>b) Support multi-strategic programs for families from rural and remote areas that include subsidised home safety equipment to prevent falls.</li> <li>c) All states and territories to adopt window safety legislation for tenanted buildings. Ensure compliance with this legislation.</li> </ul>
	<i>Lead agency (partners)</i>	<i>State and territory departments of health, state and territory departments of infrastructure and planning (Local government, strata management bodies, Kidsafe, housing provider services, Aboriginal Community Controlled Health Organisations)</i>
Road + land transport	<b>Objective 7</b>	<b>Increase child pedestrian safety</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Improve the overall compliance with speed limits, particularly on high-traffic and/or high-risk sections of the road network across all states and territories, including 40 km/hr school zones.</li> </ul>
	<i>Lead agency (partners)</i>	<i>State and territory departments of roads and transport (Schools, Parents &amp; Citizens Associations)</i>
	<b>Objective 8</b>	<b>Promote the correct use of appropriate child car seats</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Support increased community-based education on the correct use of appropriate child car seats.</li> </ul>



		<p>b) Provide subsidised access to restraint fitting services for children from rural and remote areas, socio-economically disadvantaged areas and Aboriginal and Torres Strait Islander families.</p> <p>c) Strengthen compliance with child restraint legislation in all states and territories.</p> <p><i>Lead agency (partners)</i> <i>State and territory departments of transport (Local government, restraint fitters, Kidsafe, Pre-schools, Early Childhood Health Centres, Aboriginal Community Controlled Organisations, educators, police, Child Restraint Evaluation Program)</i></p>
<b>Sports</b>	<p><b>Objective 16</b></p> <p><i>Actions</i></p> <p><b>Reduce the rate and impact of sports injuries</b></p> <p>a) Support sports clubs and schools to develop, implement and enforce safety policies and practices covering education of players and parents, compulsory use of relevant protective equipment, use of relevant modified equipment and fixtures, maintenance of sporting fields, exercise-training programs, refereeing and rules for safe play, and accreditation of coaches and coaching standards.</p> <p>b) Promote head injury awareness, including concussion management and policies, particularly in contact sports and the promotion of appropriate headgear use, e.g. horse riding, skiing and other sports with standards approved headgear such as cricket and football codes.</p> <p><i>Lead agency (partners)</i> <i>State and territory departments of sport and recreation and education (Local government, peak sports bodies and sports medicine authorities, sporting associations, Education Departments, schools, Aboriginal Community Controlled Organisations)</i></p>	
<b>Homicide and Violence</b>	<p><b>Objective 10</b></p> <p><i>Actions</i></p> <p><b>Increase primary prevention of violence and equitable access to timely, appropriate and affordable care</b></p> <p>a) Increase access to primary prevention through school and community-based programs.</p> <p>b) Provide culturally relevant services so that Aboriginal and Torres Strait Islander families experience culturally safe antenatal care.</p> <p>c) Deliver culturally competent programs to provide expectant parents with greater support and competencies<sup>47</sup> and ensure safe perinatal care.</p> <p>d) Address the inequities that drive determinants of violence and embed actions to address these.</p> <p><i>Lead agency (partners)</i> <i>State and territory departments of health (Department of Social Services, Local government, Kidsafe, Preschools, ECHC, Aboriginal Community Controlled Organisations, antenatal educators, police)</i></p>	
	<p><b>Objective 11</b></p> <p><i>Actions</i></p> <p><b>Reduce the prevalence and impact of violence</b></p> <p>a) Promote healthy and safe relationships and build gender equitable values through initiatives for children and young people.<sup>48</sup></p> <p>b) Provide support services for young people witnessing or experiencing (or who are at risk of) violence using a child-centred approach.</p> <p><i>Lead agency (partners)</i> <i>State and territory departments of health (State and territory Departments of Education, primary healthcare, schools, Aboriginal Community Controlled Organisations)</i></p>	
<b>Determinants of injury</b>	<p><b>Objective 17</b></p> <p><i>Actions</i></p> <p><b>Increase the proportion of families accessing services relevant to the first 2000 days of life.</b></p> <p>a) Increase support and care for expectant parents such that their child is given the best opportunity to develop and thrive to reduce the risk of injury and its long-term impact.</p> <p>b) Increase primary prevention for pregnant women who are at increased risk of family or domestic violence.</p> <p>c) Increase safety promotion, education, and practical guidance for parents through early childhood service settings and community touchpoints.</p> <p><i>Lead agency (partners)</i> <i>National, state and territory departments of departments of health, social services, and education (Health, Education, Family and Community Services, Housing, PHNs,</i></p>	

	<i>Early Childhood Education and Care Centres, Primary Health Care Services, Aboriginal Community Controlled Health Organisations)</i>
<b>Objective 18</b>	<b>Increase proportion of children living in supportive home environments</b>
<i>Actions</i>	a) Promote the delivery of strengths-based, family-centred approaches to provide a culturally-safe and supportive environment for families and children, including Aboriginal and Torres Strait Islander children and children from low-socio-economic areas.
<i>Lead agency (partners)</i>	<i>National, state and territory departments of child and family services and social services (Health, Education; PHNs, child and young people advocacy groups; Australian Institute of Family Services, Aboriginal Community Controlled Organisations, National Mental Health Commission)</i>
<b>Objective 19</b>	<b>Prioritise the availability of and access to culturally appropriate programs and services</b>
<i>Actions</i>	a) Support programs aimed at connection to Country and community for Aboriginal and Torres Strait Islander young people. b) Ensure health, justice and education systems and services are culturally respectful, non-discriminatory and use a strengths-based approach.
<i>Lead agency (partners)</i>	National department of health (National Indigenous Australians Agency, all national and state departments, Aboriginal Community Controlled Organisations and Health Services)
<b>Objective 20</b>	<b>Reduce the use of alcohol, and related harms of alcohol, during pregnancy</b>
<i>Actions</i>	a) Increase access to FASD screening and services for children and families. b) Improve the availability of, and access to, locally tailored and specialist FASD diagnostic services. c) Encourage paediatricians and other health professionals to provide diagnostic and coordinated care services for children with FASD. d) Raise awareness of FASD among parents, carers and communities, particularly around behaviours associated with FASD and how these relate to increased risk of injury. e) Provide culturally appropriate, tailored injury prevention programs for children with FASD.
<i>Lead agency (partners)</i>	<i>National, state and territory departments of health (Health, Education, Family and Community Services, Housing, PHNs, Early Childhood Education and Care Centres, Primary Health Care Services, Aboriginal Community Controlled Health Organisations)</i>

**Case study: Violence prevention**

- To describe the cycle of domestic violence and need for early intervention, providing an example of an effective intervention relating to families to stop the trajectory of violence and future injury

**Case study: Antenatal program**

- Describe the community project-multiagency partnership, community program

## 7. Youth (15-24 years)

The development of independence carries with it new and complex roles for young people including driving, employment, independent leisure time with peers, often greater participation in competitive sport and, in some cases, becoming parents themselves. The still developing brain of the young person, alongside these new challenges and environments, puts this group at elevated risk of both in unintentional injuries as well as intentional injuries (self-harm and violence).

### Injuries are the leading cause of death and hospitalisation of youth in Australia.

#### Suicide or self-inflicted injury

- 1<sup>st</sup> for total disease burden for males 15 to 24 years,
- 5<sup>th</sup> for females 15-24 years, accounting for 44% of the injury burden in this age group

#### Road traffic injuries – motor vehicle occupant

- 3<sup>rd</sup> leading cause for males in the 15-24 age group,
- 9<sup>th</sup> leading cause for females 15-24 years, accounting for 27% of the injury burden in this age group.<sup>11</sup>

**Violence** includes family, domestic, sexual and physical violence, as well as psychological or emotional abuse.<sup>30</sup>

Some groups are more vulnerable to violence, these include:

- Young women (18-34 years): 2.7 times more likely than women aged 35 or older to have experienced intimate partner violence in the 12 months prior to 2016;<sup>30</sup>
- Pregnant women: 1 in 12 of the women hospitalised due to spouse or domestic partner violence were pregnant (2014-15);<sup>49</sup>
- Young males (20-24 years): Highest rates of hospitalisation from assaults (250 per 100,000 people).<sup>5</sup>

**Musculoskeletal injury**<sup>[5]</sup> associated with both participation in sport and active recreational pursuits, as well as certain occupations, is also common, though not often treated in hospital settings.<sup>44</sup>

## Priority areas for action

Intentional self-harm	<b>Objective 1</b>	<b>Reduce the rate of intentional self-harm</b>
	<b>Actions</b>	<ul style="list-style-type: none"> <li>a) Increase screening for suicide risk and promote help-seeking behaviours among young people targeting priority and high risk groups including young males, and incarcerated young males where burden is highest.</li> <li>b) Support Primary Health Networks and Local Health Networks to develop integrated, whole-of-community approaches to suicide prevention and joint regional mental health and suicide prevention plans.</li> <li>c) Support evidence-based primary prevention programs to support youth mental health and emotional wellbeing, particularly in high risk groups such as young females where burden is highest.</li> <li>d) Increase access to mental health services, particularly among the priority populations.</li> </ul>
	<b>Lead agency (partners)</b>	<i>National, state and territory departments of health (mental health services), Justice and youth affairs (National Indigenous Australians Agency, State and territory departments of Education, PHNs, mental health primary healthcare, National Mental Health Commission, local government, alcohol and other drug council of Australia, AOD information and treatment services, state justice sectors, youth</i>

<sup>[5]</sup> When ICD-coded hospital data are also analysed through activity codes, the importance of both sport and recreation settings and workplaces to injury risks and rates in this age group is prominent.<sup>6</sup>

<i>focused not-for-profit organisations, Aboriginal Community Controlled Health Organisations)</i>	
	<p><b>Objective 2</b> <b>Reduce the rate of intentional self-harm among Aboriginal and Torres Strait Islander young people</b></p> <p><i>Actions</i></p> <ul style="list-style-type: none"> <li>a) Increase the capacity of health and mental health services to conduct culturally appropriate screening for individuals at risk for depression, suicide and family violence.</li> <li>b) Strengthen culturally specific, targeted interventions showing promising outcomes for suicide and self-harm working towards zero suicide.</li> <li>c) Improve Aboriginal and Torres Strait Islander access to, and experience with, mental health and wellbeing services in collaboration with Aboriginal Community Controlled Health Organisations and other service providers</li> </ul> <p><i>Lead agency (partners)</i> <i>National, state and territory departments of health (mental health services), Justice and youth affairs (National Indigenous Australians Agency, Aboriginal Community Controlled Health Organisations, National Indigenous Australians Agency, National Mental Health Commission, Family Mental Health Support Service, Australian Government Office for Youth, state and territory health authorities, PHNs, local health districts, mental health NGOs, schools and tertiary education providers, community mental health providers, Justice departments)</i></p>
	<p><b>Objective 6</b> <b>Reduce road-related injury</b></p> <p><i>Actions</i></p> <ul style="list-style-type: none"> <li>a) Strengthen graduated licensing systems (GLS) to reduce overrepresentation of young people in road crashes.</li> <li>b) Support driver licencing programs for Aboriginal and Torres Strait Islander people, people experiencing socio-economic disadvantage and those living in rural and remote areas.</li> </ul> <p><i>Lead agency (partners)</i> <i>State and territory departments of roads and transport (Schools, Parents &amp; Citizens Associations)</i></p>
	<p><b>Objective 16</b> <b>Reduce the rate and impact of sports injuries</b></p> <p><i>Actions</i></p> <ul style="list-style-type: none"> <li>a) Support sports clubs and schools to develop, implement and enforce safety policies and practices covering education of players and parents, compulsory use of relevant protective equipment, use of relevant modified equipment and fixtures, maintenance of sporting fields, exercise-training programs, refereeing and rules for safe play, and accreditation of coaches and coaching standards.</li> <li>b) Promote head injury awareness, management and policies, particularly in contact sports and the promotion of appropriate headgear use e.g. horse riding, skiing and other sports with standards approved headgear such as cricket and some football codes.</li> </ul> <p><i>Lead agency (partners)</i> <i>Sports Australia and peak sports bodies (Sporting associations, brain injury NGOs, Australian Institute of Sport, medical practitioners, coaching groups, local government, Sport and Recreation and Education state and territory departments, Department of Defence, peak sports bodies and sports medicine authorities, sporting associations, schools, Aboriginal Community Controlled Organisations)</i></p>
	<p><b>Objective 15</b> <b>Reduce the rate of workplace injuries</b></p> <p><i>Actions</i></p> <ul style="list-style-type: none"> <li>a) Strengthen safety training of young workers particularly those in construction, agriculture, health and hospitality services through multifaceted programs,</li> <li>b) Establish safety performance targets to lower the rate of falls, slips, heat exposure and burns, manual handling injuries and exposure to high decibel noise levels.</li> </ul> <p><i>Lead agency (partners)</i> <i>State and territory Work Health and Safety Regulators; Safe Work Australia (The Department of Defence, NGOs with a focus on young people and on brain and spinal cord injuries, TAFE, unions, employer associations)</i></p>

<b>Determinants of injury</b>	<b>Objective 19</b>	<b>Prioritise the availability of and access to culturally appropriate programs and services</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Support programs aimed at connection to Country and community for Aboriginal and Torres Strait Islander young people.</li> <li>b) Ensure health, justice and education systems and services are culturally respectful, non-discriminatory and use a strengths-based approach.</li> </ul>
	<i>Lead agency (partners)</i>	<i>National department of health (National Indigenous Australians Agency, all national and state departments, Aboriginal Community Controlled Organisations and Health Services)</i>

**Case study:** Lived experience of youth injury

- To describe the circumstances of how injury occurred and impact on current life-many talk about what they have achieved since their injury (first person story).

## 8. Adults (25-64 years)

The social and financial pressures on adults change the patterns of injury experienced by this age group. The environments, including the socio-economic environment, in which adults live and work, can impact the risk of self-harm, poisoning and overdose injuries, work-related injuries and transport-related injuries for this age group.

<b>Leading causes of injury</b> (DALY) <sup>1</sup> in adults aged 25-64 years:		
	<b>1. Suicide and self-inflicted</b> (39% of the injury burden)	2. Poisoning
		3. Road transport injury and
		4. Falls (Appendix B)
<b>Musculoskeletal injuries</b>	<b>Poisoning</b>	
Remain an issue and it is in this age-range that adverse long-term consequences of such injuries (e.g. osteoarthritis) start to appear and impact on quality of life. <sup>53</sup>	<ul style="list-style-type: none"><li>• #1 cause of injury for men aged 25-44 and 4<sup>th</sup> leading cause of disease burden;</li><li>• 2<sup>nd</sup> leading cause of injury burden for females 25-44 years.<sup>11</sup></li></ul>	
<b>Work-related injury and disease cost Australia \$6.8 billion in 2012-2013.<sup>51</sup></b>		
In 2016 workplace fatalities were highest in:	Highest number of fatalities is among those in the 45-54 age group and the majority of work-related injury occurs in males (85%). <sup>52</sup>	Hospitalisations from work-related injury: 234,104 cases (2006-20 to 2013-14)
<ul style="list-style-type: none"><li>• Road transport (road freight transport)</li><li>• Agriculture</li></ul>		Leading type of injury for hospitalisations was falls. <sup>50</sup>
Aboriginal and Torres Strait Islander people, people living in rural and remote areas and people from socio-economically disadvantaged areas are more likely to experience partner violence.		
Other groups in Australia who are more vulnerable to violence include people with a disability, people from culturally and linguistically diverse backgrounds and LGBTQI+ people. <sup>30</sup>		

### Priority areas for action

<b>Intentional self-harm</b>	<b>Objective 1</b>	<b>Reduce the rate of intentional self-harm</b>
	<b>Actions</b>	a) Increase the capacity of health and mental health services to conduct screening for depression, suicide and other mental health conditions. b) Increase access to screening training programs for rural and remote health service providers. c) Increase targeted interventions and public health awareness around suicide and self-harm as part of working towards zero suicide.
	<b>Lead agency (partners)</b>	Department of Health; Department of Defence; The Department of Veterans' Affairs; Department of Social Services; The Office for Women (Family Mental Health Support Service, National Indigenous Australians Agency, Australian Government Office for Youth, state and territory health authorities, PHNs, local health districts, aftercare, alternatives to ED, peer workers, mental health NGOs, schools and tertiary education providers, community mental health providers)

Poisoning	<b>Objective 2</b>	<b>Reduce the rate of intentional self-harm among Aboriginal and Torres Strait Islander young people</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Increase the capacity of health and mental health services to conduct culturally appropriate screening for individuals at risk for depression, suicide and family violence.</li> <li>b) Implement integrated planning and service delivery for Aboriginal and Torres Strait Islander people at the regional level.</li> <li>c) Strengthen culturally specific, targeted interventions showing promising outcomes for suicide and self-harm working towards zero suicide.</li> <li>d) Improve Aboriginal and Torres Strait Islander access to, and experience with, mental health and wellbeing services in collaboration with Aboriginal Community Controlled Health Organisations and other service providers</li> </ul>
	<i>Lead agency (partners)</i>	<i>Department of Health; National Indigenous Australians Agency (Aboriginal Community Controlled Health Organisations, National Indigenous Australians Agency, Family Mental Health Support Service, Australian National Mental Health Commission, state and territory health authorities, PHNs, local health districts, mental health NGOs, schools and tertiary education providers, community mental health providers, Justice departments)</i>
	<b>Objective 5</b>	<b>Reduce the rate of drug-related poisoning</b>
Road + land transport	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Support access to agonist therapies (such as best practice in methadone maintenance) to reduce opioid use and to retain patients in treatment and take-home naloxone programs.</li> <li>b) Increase opioid users' awareness about safe levels of pain control use.</li> </ul>
	<i>Lead agency (partners)</i>	<i>Department of Health (State and territory departments of health, PHNs, mental health service providers, NGOs with a core focus on young people, on alcohol and other drugs, general practitioners, Aboriginal Community Controlled Organisations)</i>
	<b>Objective 6</b>	<b>Reduce road-related injury</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Strengthen efforts in the area of high range or repeat drink-driving offenders by ensuring that the use of alcohol interlocks in private motor vehicles is consistently employed in all states and territories, in drink-driving offenders' programs for high-range or repeat offenders.</li> <li>b) Increase community campaigns to promote awareness of drink driving risks and police roadside checks on alcohol- and drug-driving.</li> <li>c) Reduce speed limits to reflect urban design and road design (e.g. reduce speeds in undivided roads; reduce urban traffic to 30km/hr).</li> </ul>
Sport	<i>Lead agency (partners)</i>	<i>Department of Infrastructure, Transport, Cities and Regional Development (State and territory departments of roads and transport and health, National Drug Driving Working Group, police, NGOs with a core focus on young people, on alcohol and other drugs, on brain or spinal cord injuries)</i>
	<b>Objective 16</b>	<b>Reduce the rate and impact of sports injuries</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Support sports clubs and schools to develop, implement and enforce safety policies and practices covering education of players, compulsory use of relevant protective equipment, use of relevant modified equipment and fixtures, maintenance of sporting fields, exercise-training programs, refereeing and rules for safe play, and accreditation of coaches and coaching standards.</li> <li>b) Provide educational resources and financial support to promote head injury, including concussion, awareness, management and policies, particularly in contact sports and the promotion of appropriate headgear use e.g. horse riding, skiing and other sports with standards approved headgear such as cricket and some football codes.</li> </ul>
	<i>Lead agency (partners)</i>	<i>Sports Australia and peak sports bodies (Sporting associations, brain injury NGOs, Australian Institute of Sport, medical practitioners, coaching groups, local government, Sport and Recreation and Education state and territory departments,</i>



		<i>Department of Defence, peak sports bodies and sports medicine authorities, sporting associations, schools, Aboriginal Community Controlled Organisations)</i>
Homicide and Violence	<b>Objective 10</b>	<b>Increase primary prevention of violence and equitable access to timely, appropriate and affordable care</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Increase primary prevention for women who are at increased risk of family or domestic violence.</li> <li>b) Engage the expertise of Aboriginal and Torres Strait Islander women and men, communities and organisations to lead in the creation and implementation of community-led solutions to build and manage change.<sup>48</sup></li> <li>c) Consider both the immediate impacts and deep underlying drivers of family violence in communities, including Aboriginal and Torres Strait Islander communities, through collective action with governments, service providers and communities.<sup>48</sup></li> </ul>
	<i>Lead agency (partners)</i>	<i>State and territory departments of health (PHNs, Aboriginal Community Controlled Organisations, antenatal educators, police)</i>
	<b>Objective 11</b>	<b>Reduce the prevalence and impact of violence</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Improve coordination across services to maximise their impact on community attitudes and behaviours that address violence.</li> <li>b) Ensure that the effects of intergenerational trauma on Aboriginal and Torres Strait Islander peoples are explicitly considered and mentioned within violence prevention for Aboriginal and Torres Strait Islander peoples, including holistic healing strategies, and by strengthening connections to culture, language, knowledge and identity.</li> <li>c) Promote accessible, coordinated and culturally sensitive support services for people at risk of partner related violence, including Aboriginal and Torres Strait Islander women and those living in rural and remote areas and those who are most socio-economically disadvantaged.</li> </ul>
	<i>Lead agency (partners)</i>	<i>State and territory departments of health (State and territory departments of education, primary healthcare, schools NGOs with a focus on women's health and safety, primary healthcare, Aboriginal Community Controlled Organisations, rural health services)</i>
Workplace	<b>Objective 15</b>	<b>Reduce the rate of workplace injuries</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Increase workplace training and policies addressing falls risks, with a focus on the construction industry, and other occupational groups at risk of falls from a height.</li> <li>b) Support programs that address musculoskeletal issues such as back injury including nurses, those in manufacturing industries and other service settings.</li> </ul>
	<i>Lead agency (partners)</i>	<i>State and territory work Health and safety regulators; Safe Work Australia (State and territory work health and safety departments, and departments of roads and transport, Department of Defence, SME Association of Australia, Master Builders Association, CMFEU, employers' associations, TAFE)</i>
Determinants of injury	<b>Objective 19</b>	<b>Prioritise the availability of and access to culturally appropriate programs and services</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Support programs aimed at connection to Country and community for Aboriginal and Torres Strait Islander young people.</li> <li>b) Ensure health, justice and education systems and services are culturally respectful, non-discriminatory and use a strengths-based approach.</li> </ul>
	<i>Lead agency (partners)</i>	<i>National department of health (National Indigenous Australians Agency, all national and state departments, Aboriginal Community Controlled Organisations and Health Services)</i>

**Case Study:** Workplace (farm related injury) - To describe the burden of workplace farm injury and provide an example of a successful workplace farm safety program



## 9. Older people (65+ years)

<b>Main causes of injury</b>	<ol style="list-style-type: none"> <li>1. Falls (61% total injury burden)</li> <li>2. Suicide and self-harm</li> <li>3. Road traffic injuries</li> </ol>
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- FALLS**
- Older people (aged 85 years or over) who have a fall (in hospital) are twice as likely to be subsequently admitted to an aged care facility, than those who do not fall.<sup>54</sup>
  - NSW data suggests that 7% of individuals over 65 who have a fall are transferred directly to residential aged care.<sup>55</sup>
  - Some population groups continue to face social and cultural inequities, leading to early onset of age-related injury such as falls.<sup>56</sup> In recognition of those inequities for example, fall prevention programs should be tailored to Aboriginal and Torres Strait Islander people aged over 55 years.<sup>57</sup>

Older people reported **elder abuse** through over 10, 900 calls made to elder abuse helplines in Australia in 2017-18

### Priority areas for action

Falls	<b>Objective 2</b> <i>Actions</i>	<b>Reduce risk of falls</b> <ol style="list-style-type: none"> <li>a) Improve access by older people living independently in the community to home environment assessment and modification opportunities combined with exercise programs that include gait, balance or functional training.</li> <li>b) Increase access to falls prevention programs for people living in rural and remote areas, including access to exercise and balance training programs.</li> <li>c) Enhance provision of and access to culturally relevant effective falls prevention programs for Aboriginal and Torres Strait Islander people aged 55 years and over.</li> <li>d) Increase medication reviews and medication education programs for older people, targeting, and in consultation with, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and people living in lower socio-economic areas.</li> </ol>
	<i>Lead agency (partners)</i>	<i>Department of Health, state and territory health departments; Department of Veterans' affairs (Primary healthcare workforce, aged care services, Aboriginal Community Controlled Organisations, Commission on Safety and Quality in Health Care, NGOs with a core focus on older people)</i>
Intentional self-harm	<b>Objective 1</b> <i>Actions</i>	<b>Reduce the rate of intentional self-harm</b> <ol style="list-style-type: none"> <li>a) Build the capacity of health professionals, notably general practitioners delivering aged care services, to be able to detect and refer those at risk of intentional self-harm.</li> <li>b) Increase culturally appropriate care within mental health and primary care services for older people. Specifically, develop and offer culturally appropriate programs to reduce intentional self-harm among older Aboriginal and Torres Strait Islander people.</li> </ol>
	<i>Lead agency (partners)</i>	<i>Department of Health, state and territory health departments; National Indigenous Australians Agency; Department of Veterans' Affairs (Royal Australasian College of General Practitioners, National Mental Health Commission, Aged care services, PHNs, Aboriginal Community Controlled Organisations, NGOs with a core focus on older people)</i>

Road + land transport	<b>Objective 6</b>	<b>Reduce road-related injury</b>
	<p><i>Actions</i></p> <p>a) Employ available evidence on best practice, to create uniform state and territory licensing requirements, in terms of the age at which medical assessments for older drivers' fitness to drive is required.</p> <p>b) Promote greater sharing of educational resources to assist older drivers, developed by some states and territories.</p> <p><i>Lead agency (partners)</i></p> <p>State and territory departments of transport (Royal Australasian College of General Practitioners, NGOs with a core focus on older people)</p>	
Homicide + Violence	<b>Objective 10</b>	<b>Increase primary prevention of violence and equitable access to timely, appropriate and affordable care</b>
	<p><i>Actions</i></p> <p>a) Increase understanding of elder abuse across Australia.</p> <p>b) Improve coordination across primary care services to maximise their impact to respond to elder abuse.</p> <p><i>Lead agency (partners)</i></p> <p>State and territory departments of health (Primary healthcare, residential care facilities)</p>	
Determinants of injury	<b>Objective 19</b>	<b>Prioritise the availability of and access to culturally appropriate programs and services</b>
	<p><i>Actions</i></p> <p>a) Support programs aimed at connection to Country and community for Aboriginal and Torres Strait Islander young people.</p> <p>b) Ensure health, justice and education systems and services are culturally respectful, non-discriminatory and use a strengths-based approach.</p> <p><i>Lead agency (partners)</i></p> <p>National department of health (National Indigenous Australians Agency, all national and state departments, Aboriginal Community Controlled Organisations and Health Services)</p>	

**Case study:** Embedding injury prevention into standard care

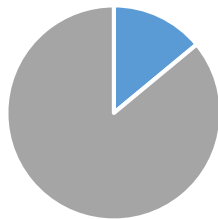
- To provide a model where injury prevention has been embedded into a standard model of care.

## 10. Cross-cutting priority areas (across the lifespan)

This section presents recommended actions for three cross-cutting factors related to the burden of injury. The three cross-cutting areas, multiply the risk and severity of all types of injuries to all life-stages and population groups. Concerted action on these three risk factors offers great potential for long-term reduction in the injury burden in Australia. In some instances, the suggested strategies have been considered alongside concepts such as affordability, the ease of uptake, anticipated acceptance, as part of the broader concepts of modifiability and feasibility.<sup>59</sup> These latter criteria are largely based on the input received from extensive consultation with stakeholders.

### Reducing injury associated with alcohol

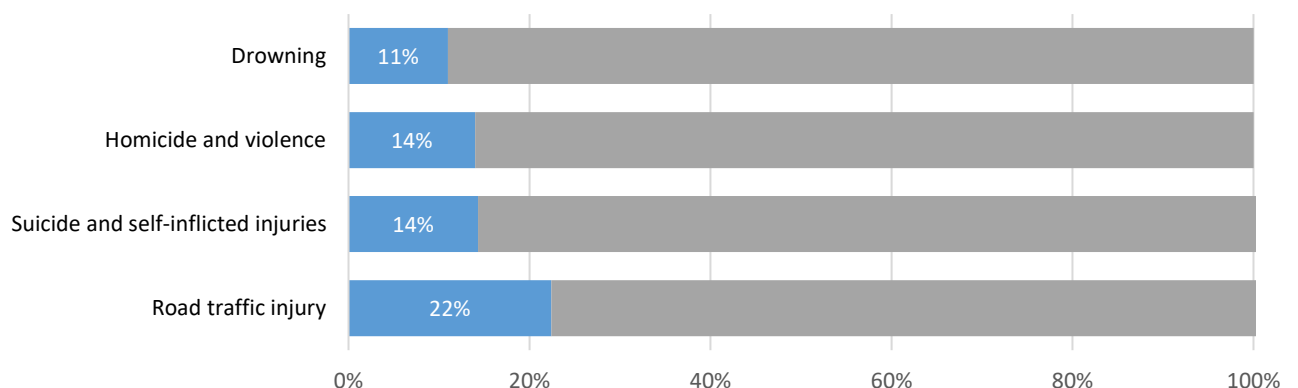
**14%** of the total injury-related burden for all Australians.<sup>11</sup>



Alcohol has been linked to injuries including:

- Pedestrian injury and fatalities
- Drownings
- Suicides
- Work accidents
- Motor vehicle crashes
- Interpersonal/family violence.<sup>60</sup>

Figure 5: Burden of injury due to alcohol (2015)<sup>61</sup>



People **18-24** are most likely age-group to require MEDICAL ATTENTION (including hospitalisation) due to alcohol-related injury.<sup>62</sup>

While **Aboriginal and Torres Strait Islander people** are **more likely to abstain** from drinking alcohol compared to non-Aboriginal people, those who do drink are more likely to drink at risky levels and are **more likely to experience injury**.<sup>62</sup>



Injuries associated with alcohol use are HIGHEST for the **lowest socio-economic** quintile compared with the highest socio-economic quintile (11.2 vs 6.2 per 1,000).<sup>11</sup>

Individuals living in **remote and very remote areas** are more likely to drink alcohol in amounts that put them at *increased risk of an alcohol-related injury*.<sup>62</sup>

## Priority areas for action

Cross cutting: Alcohol	<b>Objective 22</b>	<b>Reduce alcohol-related harm through reduced exposure</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Increase effective controls on alcohol availability, price and promotion to protect at-risk groups including youth.</li> <li>b) Implement regulatory measures to reduce alcohol advertising exposure to young people (including in sport and online).</li> </ul>
	<i>Lead agency (partners)</i>	<i>State and territory departments of health (State and territory departments of education, police, community organisations)</i>
Cross cutting: Alcohol	<b>Objective 23</b>	<b>Reduce acceptance of ‘alcohol culture’ that encourages excessive consumption</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Reduce or remove alcohol advertising in settings that may be associated with increased risk of alcohol-related violence, e.g. sporting events.</li> <li>b) Promote television program and advertising standards of reporting or even glamorising alcohol consumption</li> </ul>
	<i>Lead agency (partners)</i>	<i>National, state and territory departments of health (State departments relating to sport, sporting peak organisation and bodies)</i>
Cross cutting: Alcohol	<b>Objective 24</b>	<b>Reduce alcohol-related injuries among those who drink at levels above the recommended guidelines</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Support brief interventions in primary care settings to reduce alcohol-related injury.</li> <li>b) Increase roadside drug testing in all states and territories.</li> </ul>
	<i>Lead agency (partners)</i>	<i>National, state and territory departments of health</i>
Determinants of injury	<b>Objective 20</b>	<b>Reduce the use of alcohol, and related harms of alcohol, during pregnancy</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Provide high-quality information, education and training/counselling during the antenatal period on alcohol and pregnancy.</li> <li>b) Support delivery of proven home-based initiatives supporting parents in the antenatal and perinatal stage.</li> </ul>
	<i>Lead agency (partners)</i>	<i>Department of Health; state and territory departments of health (PHNs, health districts, Aboriginal Community Controlled Organisations, NOFASD, FASD Hub, FASD Diagnostic Services)</i>
Drowning	<b>Objective 13</b>	<b>Reduce drowning and near-drowning events</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Implement and evaluate awareness raising campaigns and enforcement of legislation regarding alcohol and water related activities.</li> </ul>
	<i>Lead agency (partners)</i>	<i>State and territory road and marine departments (State and territory health, police, Australian Water Safety Council)</i>
Road	<b>Objective 6</b>	<b>Reduce road-related injury</b>
	<i>Actions</i>	<ul style="list-style-type: none"> <li>a) Deliver local multi-component programs for reducing alcohol-impaired driving including increased awareness and visibility of roadside random alcohol and drug testing, and public education campaigns.</li> </ul>
	<i>Lead agency (partners)</i>	<i>State and territory departments of transport (Police, alcohol and other drug council of Australia, AOD information and treatment services, youth focused not-for-profit organisations, National Drug Driving Working Group, PHNs, Aboriginal Community Controlled Organisations)</i>

Homicide + Violence	<b>Objective 12</b>	<b>Reduce alcohol-related violence in public places</b>
	<i>Actions</i>	a) Provide culturally appropriate <sup>[6]</sup> multi-component programs in places where young people consume alcohol.
	<i>Lead agency (partners)</i>	<i>State and territory departments of health (Police, local government, alcohol and other drug council of Australia, AOD information and treatment services, youth focused not-for-profit organisations, Aboriginal Community Controlled Organisations)</i>

### Case study -Alcohol

## Reducing injury associated with an increase in extreme weather events

Climate change, including more frequent heatwaves and extreme weather events, has significant impacts on the health of humans.<sup>64</sup> The increasing likelihood and severity of extreme weather events and their associated impacts on the environment calls for greater attention to planning to mitigate and adapt to these changes.

Accordingly, this Strategy promotes long-term planning approaches such as housing standards and improvements in community warning and communication systems regarding extreme weather events. Policies and behaviours to reduce the likelihood or consequence of environmental events should address the driving causes and effects of vulnerability.<sup>65</sup> Anticipating changes in injury events and numbers requires reducing systemic vulnerabilities and building resilience and capability to respond to extreme weather events. The health sector also has an important role in climate change mitigation.<sup>66</sup>

Increased temperatures in Australia due to a changing climate are expected to pose direct threats to health, particularly the risk of heat stress to vulnerable communities and age-groups. Burns and respiratory problems are associated with the increasing number, intensity and coverage of bushfires, thunderstorms and dust storms.<sup>67</sup> Vulnerable groups include:

- older people;
- children and those with pre-existing health conditions such as chronic respiratory diseases, cardiovascular diseases and diabetes; and
- disadvantaged groups whose housing standards leave them with less protection against increasing temperatures.<sup>67</sup>

Australia's ageing population also means that the number of people vulnerable to the effects of increased temperatures is expected to rise.

Rural communities will be at greater risk of bushfire-related burns and suffocation and risk of suicide and self-harm associated with loss of livelihoods due to drought and extreme weather events.

People who work outdoors or in non-heat controlled environments will be at greater risk of heat stress.<sup>67</sup>

Other injuries caused by an increase in extreme weather events may include: increased risk of drowning (with flooding); mental health issues for those living in rural and remote areas and first responders; and exertional heat illnesses in those who play sport.

<sup>[6]</sup> Culturally relevant includes consideration to language, knowledge and beliefs, kinship, cultural expression, self-determination, and country and caring for country.<sup>63</sup>

## Priority areas for action

Cross cutting Extreme weather events	<b>Objective 25</b>	<b>Provide timely access to data on weather-related presentations to Emergency Departments (EDs) or hospital admissions</b>
	<b>Actions</b>	<ul style="list-style-type: none"> <li>a) Develop uniform data collection systems that capture weather-related ED presentations, hospital admissions and deaths across states and territories, and include reason for presentation, any underlying vulnerabilities and local environmental conditions at the time.</li> <li>b) Improve data collection and sharing between state and territory Health and Emergency Management Departments to ensure Australia can accurately report against targets of the Sendai Framework for Disaster Risk Reduction 2015-2030, including for death and injury.<sup>68</sup></li> </ul>
	<b>Lead agency (partners)</b>	<i>State and territory departments of health (Bureau of Meteorology)</i>
	<b>Objective 26</b>	<b>Improve the short- and long-term response to climate extremes which include a focus on preventing injuries</b>
	<b>Actions</b>	<ul style="list-style-type: none"> <li>a) Develop state/territory health plans that consider the major likely extreme weather events over the next decade and the adaptive strategies to reduce the risk of injuries associated with these events. Such events include: cyclones, floods, bushfires, and heat waves. Adaptive strategies should include primary prevention, event harm reduction, post-event strategies and adapting to cultural change. Types of injuries linked with these events include heat stress, burns, suffocation, drowning, and being struck by objects.</li> <li>b) Increase assessment and responsiveness to workplace exposure to high heat conditions, particularly in farming and other environments at increased risk.</li> <li>c) Implement workplace standards to reduce the impact of exposure to heat and hot environments.</li> </ul>
	<b>Lead agency (partners)</b>	<i>State and territory departments of health; Workplace health and safety departments (Safe Work Australia) (Primary health networks, local government, emergency services, education departments, National Farmers Federation, Aged care services, Safe Work Australia)</i>
	<b>Objective 27</b>	<b>Increase the use of innovative design and technology in transport, housing, and urban infrastructure to reduce the risk of injury associated with expected longer and more severe heat and extreme weather events</b>
	<b>Actions</b>	<ul style="list-style-type: none"> <li>a) Implement uniform requirements for housing, building and infrastructure development to provide greater protection against fire, cyclones, flooding and prolonged periods of heat.</li> <li>b) Increase affordability and accessibility of active forms of public transport to reduce reliance on private motor vehicles and increase levels of physical activity.</li> </ul>
	<b>Lead agency (partners)</b>	<i>Department of Infrastructure, Transport, Cities and Regional Development (Infrastructure) Department of Industry, Innovation and Science (building) (Australian Building Codes Board, Planning Institute Australia, Department of Environment &amp; Energy, Department of Home Affairs, Aged care services, state/territory departments of transport, planning and infrastructure, local government)</i>
	<b>Objective 28</b>	<b>Reduce preventable injuries through improvement of disaster warning and communications technologies</b>
	<b>Actions</b>	<ul style="list-style-type: none"> <li>a) Review new and emerging telephone-based warnings technologies to ensure continued ability to deliver extreme weather and emergency warnings, particularly to vulnerable groups.</li> </ul>

	<p>b) Deliver the next generation of communications services for emergency services workers (Public Safety Mobile Broadband) to ensure first responders have access to state-of-the-art situational awareness and to improve their operational effectiveness.</p> <p><i>Lead agency (partners)</i> Department of Home Affairs, state &amp; territory emergency management departments, Bureau of Meteorology (Department of Communications, state &amp; territory communication departments)</p>
<b>Objective 29</b>	<b>Improve response to the threat of physical and social impacts of climate change and extreme weather events</b>
<i>Actions</i>	<p>a) Increase uptake of evidence-based, risk management approaches to climate change.</p> <p>b) Ensure both mitigation and adaption to climate change are built into policies of health agencies.</p>
<i>Lead agency (partners)</i>	Department of the Environment and Energy (Department of Home Affairs, state and territory health departments of health and transport, Emergency Management Australia)

## Better planning of the built environment

Australia is one of the world's most urbanised countries, with almost 90% of people living in urban areas.<sup>67</sup> There are major opportunities for long-term reduction in injury risks with better urban planning for safety. As our population grows and an increasing proportion of people live in urban areas, it is important that injury prevention, alongside physical activity promotion, is an integral part of urban planning. Attention to traffic calming and reductions in motor vehicle use in urban areas, and to housing standards to prevent injury, are among the priority strategies for creating safer built environments.

Planning policies at state/territory and local levels should consider the safety of all age groups, and, different groups that use the space (e.g. road user groups) or safe mixed-use development and hazard removal or mitigation.

### Priority areas for action

<b>Cross cutting</b>	<b>Objective 30</b>	<b>Improve urban planning to promote health and safety</b>
	<i>Actions</i>	<p>a) Increase safer travel routes for cyclists and pedestrians in urban planning for commuters and for travel to school.</p> <p>b) Increase accessibility of public transport options through better planning of commuter parking and public transport options.</p>
	<i>Lead agency (partners)</i>	Department of Infrastructure, Transport, Cities and Regional Development (State and territory departments of transport, local government)
<b>Determinants of injury</b>	<b>Objective 21</b>	<b>Reduce injuries associated with housing and public spaces through better design and design standards</b>
	<i>Actions</i>	<p>a) In the design of houses, public spaces, public buildings and their surrounds, consider the risk factors for injuries, notably falls from a height, slips and trips, driveway run-overs, drowning and unintentional poisoning.</p> <p>b) Embed injury prevention components, which address the major design features of planning to promote safety, in the curriculum of the training and education of architects, civil engineers, urban planners, and landscape designers.</p> <p>c) Ensure that these standards are equally applied to people living in low-cost housing.</p>
	<i>Lead agency (partners)</i>	Department of Health (Injury prevention professionals, Universities, professional associations of architects, building designers, civil engineers, urban planners)

Falls	<b>Objective 3</b>	<b>Reduce falls in public spaces due to better design of public buildings, facilities and paths/walk ways</b>
	<i>Actions</i>	a) Include design features to reduce slips and trips by all age groups, in all plans for public buildings, facilities and paths/walk ways. This should include attention to surfacing, lighting, railings and seating.
	<i>Lead agency (partners)</i>	<i>Department of Infrastructure, Transport, Cities and Regional Development (State and territory departments of transport, local government)</i>
Road + land transport	<b>Objective 9</b>	<b>Reduce injuries to vulnerable road users through legislation and better design of road infrastructure</b>
	<i>Actions</i>	a) Review speed limits in urban, built up areas as a means of reducing crashes, and to protect children, older pedestrians, and cyclists. b) Support speed reduction measures engineered into residential streets and high pedestrian traffic areas c) Ensure that public transport options are made more accessible and affordable, with a view to reducing traffic in retail and business districts. d) Increase road safety initiatives targeting rural and remote areas.
	<i>Lead agency (partners)</i>	<i>State and territory departments of transport (Local government, police departments)</i>



## 11. Current research gaps

The following provides key research gaps identified for each life stage and cross cutting area.

<b>Babies and children (0-14 years)</b>
<ul style="list-style-type: none"> <li>• Data collection and screening during the antenatal period. (Note: As of 1 July 2019, the National Perinatal Data Collection has begun to collect alcohol use in pregnancy, however, the data quality is unknown);</li> <li>• Linked data from antenatal period to early childhood and through to other life-stages;</li> <li>• Availability of consistent outcome measures and interventions to allow comparisons across interventions and injury causes;</li> <li>• Long-term and economic evaluations of family and early-life interventions (including to reduce maltreatment to children and self-harm by children);</li> <li>• Post-traumatic stress among children and their parents following an injury;</li> <li>• Effective intentional self-harm prevention targeting 10-14 year olds;</li> <li>• Develop and evaluate drowning prevention programs targeting older children.</li> </ul>
<b>Youth (15-24 years)</b>
<ul style="list-style-type: none"> <li>• Evidence on interventions to reduce poisoning, overdose and drowning among young people, including a focus on Aboriginal and Torres Strait Islander people;</li> <li>• Evidence on workplace injury burden and causes among young people, including a focus on young Aboriginal and Torres Strait Islander people;</li> <li>• The cost of acquired brain and spinal cord injuries to young people and into later years (direct and indirect costs);</li> <li>• Evidence on effective legislative and environment measures to reduce violence among young people;</li> <li>• Effectiveness of interventions to prevent road trauma associated with other drugs;</li> <li>• Innovative models to address the health impacts of violence against women and girls, particularly focusing on those at greatest risk.</li> </ul>
<b>Adults (25-64 years)</b>
<ul style="list-style-type: none"> <li>• Evidence on components of successful interventions that reduce the risk of violence experienced by Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, the LGBTIQ+ community, people who have been incarcerated and people with a disability;</li> <li>• Evidence to quantify the prevalence, burden of injury and access to rehabilitation for Aboriginal and Torres Strait Islander people following a workplace injury.</li> <li>• Reliable and up to date information on suicide and self-harm;</li> <li>• The incidence and differences in injury for individuals with disability across the lifespan, including for Aboriginal and Torres Strait Islander people, to develop evidence-based strategies to reduce injury in this cohort;</li> <li>• Data regarding family, domestic and sexual violence is limited, with high level summary measures generally monitored through the ABS Personal Safety Survey and community attitudes through the National Community Attitudes towards Violence Against Women Survey , (however this only captures attitudes on violence against women).</li> </ul>
<b>Older people (65+ years)</b>
<ul style="list-style-type: none"> <li>• Road traffic injuries among disadvantaged population groups, in relation to countermeasures for older people;</li> <li>• The effectiveness of programs in preventing burns in older people;</li> <li>• Cost effectiveness of programs in rural and remote areas to reduce injuries to older people through improvements in housing standards with specific attention to burns and falls and to exercise and balance programs to improve mobility;</li> </ul>

<ul style="list-style-type: none"> <li>• Effectiveness of countermeasures to address elder abuse and social isolation;</li> <li>• Effectiveness of hospital-based and residential care-based multifactorial interventions particularly for people with a prior fall event and others identified at high risk of falling. Strategies for where there is some evidence include, gentle exercise, including Tai Chi and walking, environmental modification, vitamin D supplementation and hip protectors.</li> </ul>
<b>Reducing injury associated with alcohol</b>
<ul style="list-style-type: none"> <li>• National prevalence of FASD;</li> <li>• Evidence of increased risk of harm and injury to those with FASD;</li> <li>• Evidence on effectiveness of alcohol-related violence programs. Strategies could include community mobilisation, could include responsible beverage service training, stricter enforcement of licensing laws, house policies to address at risk drinking (e.g. no shots after mid-night) and environmental controls (e.g. use of plastic vessels after mid-night; security guards to reduce over-crowding). External environmental controls could include increasing the availability and ease of access to public transport for even late hours, and visible police presence.</li> </ul>
<b>Reducing injury associated with an increase in extreme weather events</b>
<ul style="list-style-type: none"> <li>• Incidence and trends of injuries associated with extreme weather events, through Emergency Department data, hospital admissions and deaths as well as sentinel data on General Practitioner visits;</li> <li>• Inclusion of weather events into datasets;</li> <li>• Understanding size of the problem of occupational heat stress, the age and occupational groups at greatest risk;</li> <li>• Understanding sports related impacts of weather events, including heat stress and air quality impacts, and the groups at greatest risk;</li> <li>• Identification of effective emergency warning messages and strategies for different vulnerable population groups by age, culture, literacy levels and geographic location;</li> <li>• Prediction and response to injury due to weather extreme as they emerge.</li> </ul>
<b>Better planning of the built environment</b>
<ul style="list-style-type: none"> <li>• Exploration of barriers to adopting safe urban design.</li> <li>• Exploration of barriers to adopting known effective countermeasures (e.g reduced speed limits in built environments to 30km/hr).</li> </ul>

## 12. Making progress

To achieve the Vision of this Strategy, infrastructure at national, state/territory and local levels needs to be established to deliver:

1. **Governance** – coordination and collaboration across key sectors and across governments spearheaded by a lead agency.
2. **Engagement** with local agencies and the community, including raising awareness that injuries are preventable.
3. **Resourcing** – funding of injury prevention programs and policies and workforce.
4. **Data and research** – the collection of national, state and territory and regional data and data on priority populations, collation of existing evidence and implementation of targeted research projects. This includes committing to principles of Indigenous data governance and sovereignty.
5. **Monitoring and reporting** – a monitoring and reporting framework to map progress and outcomes resulting from implementation of the Strategy.

To coordinate this work, it is recommended that a **National Injury Prevention Lead Agency** is established that will:

- Facilitate and encourage collaboration between stakeholders across academia, government agencies, non-government organisations, industry bodies and community groups.
- Foster intersectoral communication at state and territory level for action on injury prevention priority areas.

This agency should be adequately resourced to:

- Provide governance for the National Injury Prevention Strategy;
- Facilitate collaboration and engagement between stakeholders across academia, government representatives, non-government organisations, industry bodies and community groups;
- Provide an accessible, up-to-date clearinghouse of evidence-based approaches and resources;
- Manage targeted programs and research;
- Track progress on the Strategy through development of a monitoring and evaluation framework and tools;
- Support timely, national, state and territory and regional open access data that, and when appropriate, offers the context and story to injury events, as well as advocating for the inclusion of priority populations as standard practice in data collection and analysis;
- Advocate for consistent collection and coding of national data to compare injury data across states and territories; and
- Advocate for the collection of data that relates to Aboriginal and Torres Strait Islander people adheres to data sovereignty<sup>[7]</sup> and data governance.

*State and territory governments* should also seek to:

- *Develop and implement* injury prevention action plans;
- *Collaborate* across departments to share resources, knowledge and opportunities for action,

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<sup>[7]</sup> Data sovereignty is “the right to determine the means of collection, access, analysis, interpretation, management, dissemination and reuse of data pertaining to the Indigenous peoples from whom they have been derived, or to whom they relate”.<sup>69</sup> It is “linked with Indigenous peoples’ right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as their right to maintain, control, protect and develop their intellectual property over these”(p. xxii).<sup>70</sup>

- Work with local governments to ensure that relevant programs are operationalised and policies are enacted and monitored;
- Consult regularly with the community to identify local priorities and resources;
- Effectively *engage* local partners (such as NGOs, local governments, the community, relevant industry groups and peak bodies) in the delivery of injury prevention strategies;
- *Build on* and *resource* effective existing services and programs to implement state/territory action plans; and
- Provide resources that target new priority evidence-based actions.

*Local governments and agencies* should aim to:

- Provide a platform to easily share lessons learnt, outcomes and resources;
- *Engage* in culturally appropriate consultation and collaboration, tailored to local contexts and settings, and build on current activities that are known to work well,
- Build on and resource effective existing services and programs;
- Coordinate services so that those offering complementing services can conduct comprehensive, multi-faceted approaches (e.g. an organisation specialising in safety education for parents and an organisation specialising in conducting professional development for early childhood teachers combine to deliver a comprehensive service); and
- If based in an education facility (school, early childhood service), implement and embed injury prevention programs in the curriculum and across activities outside the classroom.

### **Monitoring and Reporting**

A coordinated national effort to monitor and evaluate the Strategy will require:

- Development of a *monitoring and evaluation framework* to assess progress on the outcome indicators, objectives, and changes in injury in Australia;
- Development of *measures* to examine capacity for action on the priority areas;
- Development of measures to assess and reduce inequities associated with the burden of injury;
- Identification of short, medium and long-term indicators of progress against the recommended actions by national government departments, state and territory governments and non-government agencies;
- Consideration of the applicability of data such as those available from the [Aboriginal and Torres Strait Islander Health Performance Framework](#);
- Evaluation of programs from the outset of program development;
- A platform to easily share lessons learnt, outcomes and resources; and
- Flexibility, to ensure that as work progresses, new measures of success may be identified.

This monitoring will also assist in meeting Australia's reporting responsibilities for progress in areas such as the United Nations Sustainable Development Goals global indicator frameworks.

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## Appendix A - Burden of disease overview

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### Rank of external causes of injury by age group

#### Drowning

- Seventh leading cause of all burden of disease for children <5 years.<sup>1</sup>
- Leading cause of injury burden for children aged 1-4 years.<sup>1</sup>

#### Falls

- Third leading cause of burden of injury among children (0 – 14 years).<sup>1</sup>
- Leading cause of injury burden among older adults (65 years and over).<sup>1</sup>
- Fifth leading cause of burden of disease (all diseases and injuries) among people aged over 85 years.<sup>71</sup>

#### Homicide and violence

- Violence (including family, domestic and sexual violence) has lifelong impacts on both victims and perpetrators and is considered a major health and welfare issue in Australia.<sup>30</sup>
- Violence can affect an individual's health, wellbeing, education, relationships and housing.<sup>30</sup>
- It is the second leading cause of injury burden in children aged <1 year and the third leading cause of injury burden in children aged 1-4 years.<sup>1</sup>
- Sixth leading cause of injury burden in the 15-64 age group.<sup>1</sup>
- Current data indicates that 1 in 6 women (17%) and 1 in 16 men (6.1%) report having experienced physical or sexual violence from a current or previous partner they lived with (since the age of 15).<sup>72</sup>

#### Poisoning and overdose

- Includes: adverse effects due to correct dosing of prescribed medications, under or over dosing of prescribed medication, and poisoning by overdose of licit and illicit substances)
- Fourth leading cause of burden of all disease among males aged 25-44 years.<sup>1</sup>
- Second leading cause of injury burden in adults aged 24-64 years, and the fourth leading cause in those aged 15-24 years.<sup>1</sup>

#### Road transport injuries

- Third leading cause of total burden of disease for males in the 15-24 age group (5.7% of total burden) and the ninth leading cause for females in the 15-24 age group (3.3% of total burden).<sup>11</sup>
- Fourth leading cause of total injury burden (15%), the second leading cause in those aged 0-14 years and 15-24 years, and the third leading cause in those aged 25-64 years.<sup>1</sup>
- Motor vehicle occupant injuries represent 17% of the Aboriginal and Torres Strait Islander burden of injury.<sup>11</sup>



### **Intentional self-harm (Suicide and self-inflicted injury)**

- Leading cause of injury burden, accounting for 33% of the total injury burden.<sup>1</sup>
- Leading cause of injury burden in adults aged 15-24 years and 25-64 years, and the second leading cause in older adults aged 65 years and older.<sup>1</sup>
- Accounts for 30% of the total burden of injury for Aboriginal and Torres Strait Islander people.<sup>12</sup>
- Males aged 20-24 years have the highest burden of suicide.<sup>11</sup>

### **Work-place fatalities**

- Fatality is highest in number among those in the 45-54 year age group.
- Work-related injury and disease cost Australia \$61.8 billion in 2012-2013.<sup>73</sup>
- Hospitalisations due to work-related injury amounted to a total of 234,104 cases in the period 2006-2007 to 2013-2014.
- The majority of work-related injury occurs in males (85%).
- The agriculture sector has the highest fatality rate of any Australian industry.<sup>74</sup>

### **Sport injury**

- In 2012-2013 sports injury resulted in more than 14,000 days in hospital for head injury and 9,500 days for knee injury.<sup>75</sup>

## Appendix B - Policy and Strategy Context

Strategy	Developed by	Date range	Specific populations	Injury focus	Related objective
<a href="#">2018 Inquiry into the National Road Safety Strategy</a>	Independent	-	Aboriginal and Torres Strait Islander people, Older drivers	Road/ transport	6, 7, 9, 27
<a href="#">Assessment Framework</a>	Infrastructure Australia	2018	-	Injury implications for the built environment	4, 9, 21, 30
<a href="#">Australian Disaster Preparedness Framework</a>	Australia-New Zealand Emergency Management Committee	2018	All populations	Injury impacts of weather events	25, 26, 27, 28, 29
<a href="#">Australian graduated licensing scheme policy framework</a>	Transport for NSW on behalf of the Austroads Road Safety Taskforce	2014	Young Australians (15 to 24 years), adults, older adults, Aboriginal and Torres Strait Islander people	Road/transport	6
<a href="#">Australian Water Safety Strategy 2016-2020</a>	Australian Water Safety Council	2016-2020	Children, Older people	Drowning	13
<a href="#">Healthy, Safe and Thriving: National Strategic Framework for Child and Youth Health</a>	Council of Australian Governments - Health Council	2015-	Aboriginal and Torres Strait Islander people, Children	Road/transport, Self-harm, falls, drowning, violence, homicide	1, 2, 3, 6, 7, 8, 13, 17, 18
<a href="#">Investing in the Early Years: A National Early Childhood Development Strategy</a>	Council of Australian Governments	2009-2020	Aboriginal and Torres Strait Islander people, Children	Self-harm, violence, safe environments, early start	3, 7, 8, 10, 13, 14, 16, 17, 18, 20
<a href="#">Mental Health and Suicide Prevention Monitoring and Reporting Framework</a>	National Mental Health Commission	2018-2022	Aboriginal and Torres Strait Islander people, Children	Suicide	1, 2, 19, 22
<a href="#">National Aboriginal and Torres Strait Islander Education Strategy</a>	Education Council	2015	Aboriginal and Torres Strait Islander people, children	-	6
<a href="#">National Aboriginal and Torres Strait Islander Health Plan 2013- 2023</a>	DOH	2013-2023	Aboriginal and Torres Strait Islander people, Children	Road/transport, Self-harm (mental health and substance misuse)	1, 2, 6, 10, 11, 17, 18, 19, 20
<a href="#">National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019</a>	DOH	2014-2019	Aboriginal and Torres Strait Islander	Suicide (Mental health)	1, 2, 5, 10, 11, 19, 22, 24
<a href="#">National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013</a>	DOH	2013-2023	Aboriginal and Torres Strait Islander	Suicide, violence, homicide	1, 2, 10, 11, 17, 18, 19
<a href="#">National Action Plan for the Health of Children and Young people</a>	DOH	2020-2030	Children and young people; rural and remote, Aboriginal and Torres Strait Islander, born into poverty, culturally and linguistically	Injuries acknowledged generally, injury types not specified	1, 2, 3, 6, 8, 7, 10, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24

Strategy	Developed by	Date range	Specific populations	Injury focus	Related objective
			diverse, living with disability, living in out of home care, incarcerated, LGBTQI+, homeless		
<a href="#">National Ageing and Aged Care Strategy For people from Culturally and Linguistically Diverse (CALD) backgrounds</a>	DSS	2012-2017	Mentions language needs of Aboriginal and Torres Strait Islander people; Rural / remote; Culturally and linguistically diverse populations including older people with refugee-like experiences, LGBTQI+	-	1, 3, 6, 11
<a href="#">National Alcohol Strategy 2019-2028</a>	Ministerial Drug and Alcohol Forum	2019-2028	Remote areas; Children Pregnant women, LGBTQI+ community	Harm from alcohol: Contributing to avoidable injury and road accidents	6, 12, 13, 17, 20, 22, 23, 24
<a href="#">National Climate Resilience and Adaptation Strategy</a>	Commonwealth of Australia	2015	All populations	Injury impacts of weather events	25, 26, 27, 28, 29
<a href="#">National Disaster Risk Reduction Framework</a>	National Resilience Taskforce, Australian Government Department of Home Affairs	2018	All populations	Injury impacts of weather events, including mental health	25, 26, 27, 28, 29
<a href="#">National Drug Strategy 2017-2026</a>	DOH	2017-2026	Aboriginal and Torres Strait Islander people, young people, older people, people with mental health conditions, culturally and linguistically diverse, those in contact with criminal justice system, LGBTQI+	Injury-related harm from drugs: Road/transport suicide, mental health disorders, violence	6, 12, 13, 17, 20, 22, 23, 24
<a href="#">National Falls Prevention for Older People Plan 2004 Onwards</a>	National Public Health Partnership	2004+	Older people	Falls	3
<a href="#">National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028</a>	DOH	2018-2028	Women, Children		10, 17, 20
<a href="#">National Framework for Universal Child and Family Health Services</a>	AHMAC*	2011-unclear	Aboriginal and Torres Strait Islander people identified within strategies Children	Violence and self-harm - focus on perinatal mental health, parental and child mental health.	3, 7, 8, 10, 11, 13, 14, 16, 17, 18, 20

Strategy	Developed by	Date range	Specific populations	Injury focus	Related objective
<a href="#">National Health Emergency Response Arrangements</a>	Department of Health and Ageing	2011	Australian population	Injury relating to climate change and natural disasters	25, 26, 27, 28, 29
<a href="#">National Men's Health Strategy</a>	DOH	2020-2030	Men and boys. Nine priority populations specific to males; rural and remote, Aboriginal and Torres Strait Islander, socioeconomically disadvantaged, males with disability, culturally and linguistically diverse, LGBTIQ+, veterans, socially isolated, and in the criminal justice system	Suicide, self-harm (mental health and substance misuse), assault and homicide, poisoning, road/transport burns, drowning, falls, and injuries in the workplace	1, 2, 5, 6, 11, 12, 17, 18, 19, 22, 23, 24
<a href="#">National Plan to Reduce Violence against Women and Their Children</a>	Council of Australian Governments	2010 - 2022	Women, Children, Aboriginal and Torres Strait Islander people	Violence, homicide	10, 11, 18, 18
<a href="#">National Preventative Health Strategy – 'Australia the Healthiest Country by 2020'</a>	DOH	2009 - 2020	Aboriginal and Torres Strait Islander people	Public transport identified as lever to engage communities, alcohol and substance use	10, 15, 17, 18, 20, 22, 24, 29
<a href="#">National Road Safety Action Plan 2018-2020</a>	Transport and Infrastructure Council	2018-2020	All populations	Road/transport, drink driving	6, 7, 9, 27, 29
<a href="#">National Road Safety Strategy 2011-2020</a>	Australian Transport Council	2011-2020	Aboriginal and Torres Strait Islander people are a priority population	Substance use, alcohol, road/transport	6, 7, 9, 27, 29
<a href="#">National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023</a>	Prime Minister and Cabinet	2017-2023	Aboriginal and Torres Strait Islander, Children	Suicide, violence, homicide	1, 2, 10, 11, 17, 19
<a href="#">National Strategic Framework for Chronic Conditions</a>	Australian Health Minister s' Advisory Council	2017	Australian population focus on Aboriginal and Torres Strait Islander, rural and remote	Alcohol as risk factor, other chronic disease associated with injury	12, 15, 23
<a href="#">National Strategic Framework for Rural and Remote Health</a>	Rural Health Standing Committee	2016	Rural / remote	Suicide, workplace	1, 2, 3, 6, 9, 10, 11, 12, 13, 15, 17, 20, 22, 23, 24, 29,
<a href="#">National Women's Health Strategy</a>	DOH	2020-2030	Women and girls. Six priority populations, specific to women and girls; pregnant women and their children, rural and remote,	Suicide and self-harm, road/transport	1, 2, 5, 6, 10, 11, 12, 17, 18, 19, 20, 22, 23, 24

Strategy	Developed by	Date range	Specific populations	Injury focus	Related objective
			Aboriginal and Torres Strait Islander, low socioeconomic background, living with a disability and carers, and culturally and linguistically diverse		
<a href="#">Protecting Children is Everyone's Business – National Framework for Protecting Australia's Children 2009-2020</a>	Council of Australian Governments	2009-2020	Aboriginal and Torres Strait Islander people are a priority population, children	Suicide, poisoning, violence (embedded in focus on mental health)	10, 17, 18, 20
<a href="#">Safe Work Australia's Australian Work Health and Safety Strategy 2012-2022</a> <a href="#">Safe Work Australia's Return to Work Strategy 2020-2030</a>	Safe Work Australia	2012-2022	Workers	Road/transport, workplace	15
<a href="#">The Fifth National Mental Health and Suicide Prevention Plan</a>	Council of Australian Governments-Health Council	2017-2022	Aboriginal and Torres Strait Islander people are a priority population	Suicide	1, 2, 10, 11, 17, 18, 19
<a href="#">The Nest Action Agenda: Improving the wellbeing of Australia's children and youth while growing our GDP by over 7%</a>	Australian Research Alliance for Child and Youth	2013-2025	Aboriginal and Torres Strait Islander people are a priority population, children	Road/transport, violence, substance use	3, 7, 17, 18, 22, 23, 27, 29
<a href="#">The Roadmap for National Mental Health Reform 2012-2022</a>	Council of Australian Governments	2012-2022	All Australians	Mental health, suicide/intentional self-harm	1, 2
<a href="#">Veteran Mental Health and Wellbeing Strategy</a>	Department of Veterans' Affairs	2013-2023	Veterans	Suicide and intentional self-harm, AOD	1, 2, 5, 22, 24

DoH- Commonwealth Department of Health, DOH\*- Developed by the Department of Health through Australian Health Ministers' Conference (AHMC), Department of Infrastructure, Regional Development and Cities through the Transport and Infrastructure Council, Independent – Chaired by Associate Professor Jeremy Woolley, Centre for Automotive Safety Research at the University of Adelaide, and Dr John Crozier, Chair of the Royal Australasian College of Surgeons' Trauma Committee, Developed with Commonwealth, and State and the Northern Territory governments by the Rural Health Standing Committee

## Appendix C - Rank of external causes of injury by age group<sup>1</sup>

### Overall

Rank	External cause	Total DALYs <sup>a</sup>	%
1	Suicide and self-inflicted injuries	135373	33%
2	Falls	66521	16%
3	Poisoning	62681	15%
4	Road transport injury	62318	15%
5	Other unintentional injuries	28533	7%
6	Homicide and violence	18291	5%
7	Other land transport injuries	11508	3%
8	Drowning	10744	3%
9	All other external causes of injury	6596	2%
10	Fire, burns and scalds	3396	1%

Note: a) DALYs = disability adjusted life years

### 0-14 years

Rank	External cause	Total DALYs <sup>a</sup>	%
1	Other unintentional injuries	4332.8	20%
2	Road transport injury	3231.2	15%
3	Falls	3132.6	15%
4	Drowning	2978.1	14%
5	Homicide and violence	2337.5	11%
6	Other land transport injuries	2318.6	11%
7	Suicide and self-inflicted injuries	1498.2	7%
8	Fire, burns and scalds	651.9	3%
9	Poisoning	482.2	2%
10	All other external causes of injury	288.8	1%

Note: a) DALYs = disability adjusted life years

### 15-24 years

Rank	External cause	Total DALYs <sup>a</sup>	%
1	Suicide and self-inflicted injuries	27383	44%
2	Road transport injury	16766	27%
3	Other unintentional injuries	4560	7%
4	Poisoning	3655	6%
5	Falls	3268	5%
6	Homicide and violence	3061	5%
7	Other land transport injuries	1859	3%
8	Drowning	1583	3%
9	Fire, burns and scalds	313	0%
10	All other external causes of injury	247	0%

Note: a) DALYs = disability adjusted life years

**25-64 years**

Rank	External cause	Total DALYs <sup>a</sup>	%
1	Suicide and self-inflicted injuries	98404	39%
2	Poisoning	56744	22%
3	Road transport injury	36460	14%
4	Falls	17632	7%
5	Other unintentional injuries	14866	6%
6	Homicide and violence	12275	5%
7	Other land transport injuries	5980	2%
8	Drowning	5325	2%
9	All other external causes of injury	2947	1%
10	Fire, burns and scalds	1726	1%

Note: a) DALYs = disability adjusted life years

**65 years and older**

Rank	External cause	Total DALYs <sup>a</sup>	%
1	Falls	42488	61%
2	Suicide and self-inflicted injuries	8087	12%
3	Road transport injury	5860	8%
4	Other unintentional injuries	4774	7%
5	All other external causes of injury	3114	4%
6	Poisoning	1800	3%
7	Other land transport injuries	1350	2%
8	Drowning	858	1%
9	Fire, burns and scalds	705	1%
10	Homicide and violence	618	1%

Note: a) DALYs = disability adjusted life years

**Children breakdown****<1 years**

Rank	External cause	Total DALYs <sup>a</sup>	%
1	Other unintentional injuries	1200	48%
2	Homicide and violence	677	27%
3	Road transport injury	222	9%
4	Drowning	202	8%
5	Falls	101	4%
6	Other land transport injuries	63	3%
7	Fire, burns and scalds	28	1%
8	Poisoning	10	0%
9	All other external causes of injury	4	0%
10	Suicide and self-inflicted injuries	0	0%

Note: a) DALYs = disability adjusted life years

**1-4 years**

Rank	External cause	Total DALYs <sup>a</sup>	%
1	Drowning	1935	28%
2	Other unintentional injuries	1101	16%
3	Homicide and violence	961	14%
4	Road transport injury	854	12%
5	Other land transport injuries	815	12%
6	Falls	638	9%
7	Fire, burns and scalds	288	4%
8	Poisoning	215	3%
9	All other external causes of injury	96	1%
10	Suicide and self-inflicted injuries	0	0%

Note: a) DALYs = disability adjusted life years

**5-9 years**

Rank	External cause	Total DALYs <sup>a</sup>	%
1	Falls	1086	23%
2	Other unintentional injuries	983	20%
3	Road transport injury	854	18%
4	Drowning	751	16%
5	Other land transport injuries	690	14%
6	Homicide and violence	268	6%
7	Fire, burns and scalds	149	3%
8	Poisoning	27	1%
9	All other external causes of injury	17	0%
10	Suicide and self-inflicted injuries	0	0%

Note: a) DALYs = disability adjusted life years

**10-14 years**

Rank	External cause	Total DALYs <sup>a</sup>	%
1	Suicide and self-inflicted injuries	1498	21%
2	Falls	1307	19%
3	Road transport injury	1301	19%
4	Other unintentional injuries	1049	15%
5	Other land transport injuries	750	11%
6	Homicide and violence	431	6%
7	Poisoning	230	3%
8	Fire, burns and scalds	186	3%
9	All other external causes of injury	172	2%
10	Drowning	91	1%

Note: a) DALYs = disability adjusted life years



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## Strategy development timeline

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Key activities and consultations have informed the development of the Strategy including:

- Two Round Table discussions held in March 2019;<sup>76</sup>
- A review of existing peer-reviewed published literature reviews ('review of reviews'), relating to injury prevention internationally, finalised in July 2019;<sup>77</sup>
- Stakeholder consultations held across Australia with approximately 95 key stakeholders from government and non-government agencies, networks and communities in August and September 2019;
- An Expert Advisory Group (EAG) comprising government and non-government representatives and chaired by the Australian Government Department of Health convened to guide and advise on the development of the Strategy;<sup>78</sup>
- Australian Government consultation in December 2019 with key Commonwealth Departments.
- State Government and community consultation in May 2020.