THE NATIONAL INJURY PREVENTION AND SAFETY PROMOTION PLAN: 2004 - 2014

July 2005

THE NATIONAL INJURY PREVENTION AND SAFETY PROMOTION PLAN: 2004 - 2014

July 2005

National Public Health Partnership (NPHP). 2004. The National Injury Prevention and Safety Promotion Plan: 2004-2014. Canberra: NPHP.

This paper is available from the Injury Prevention pages of the NPHP website: *www.nphp.gov.au/publications/a_z.htm* and the Department of Health and Ageing website: *www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-strateg-injury-index.htm*

© Commonwealth of Australia 2005

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from the Commonwealth. Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Attorney General's Department, Robert Garran Offices, National Circuit, Canberra ACT 2600 or posted at *http://www.ag.gov.au/cca*

Department of Health and Ageing

Publications Approval Number: 3738 (JN 9220)

ISBN: 0 642 82777 X

The *National Injury Prevention and Safety Promotion Plan: 2004 – 2014* was endorsed by the Australian Health Ministers on 28 July 2005 as part of a package of National Injury Prevention Plans. This package consists of:

The *National Injury Prevention and Safety Promotion Plan: 2004 – 2014*;
The *National Aboriginal and Torres Strait Islander Safety Promotion Strategy*; and
The *National Falls Prevention for Older People Plan: 2004 Onwards*.

Acknowledgements

The Strategic Injury Prevention Partnership (SIPP) recognises that the advice and comments from the National Plan subcommittee of the SIPP made a significant contribution to the development of the Plan. The Subcommittee consisted of the following members:

James Harrison – Australian Institute of Health and Welfare (AIHW) National Injury Surveillance Unit

Pam Albany and Rebecca Mitchell – NSW Health

Richard Franklin – Australian Injury Prevention Network

Michael Tilse – Queensland Health

Bruce Wight and Rae Scott – Australian Government Department of Health and Ageing

Rod McClure – Griffith University

SIPP Secretariat – Australian Government Department of Health and Ageing

SIPP acknowledges the contributions of the many individuals and organisations who provided written submissions on the draft plan and participated in national and/or jurisdictional consultation workshops.

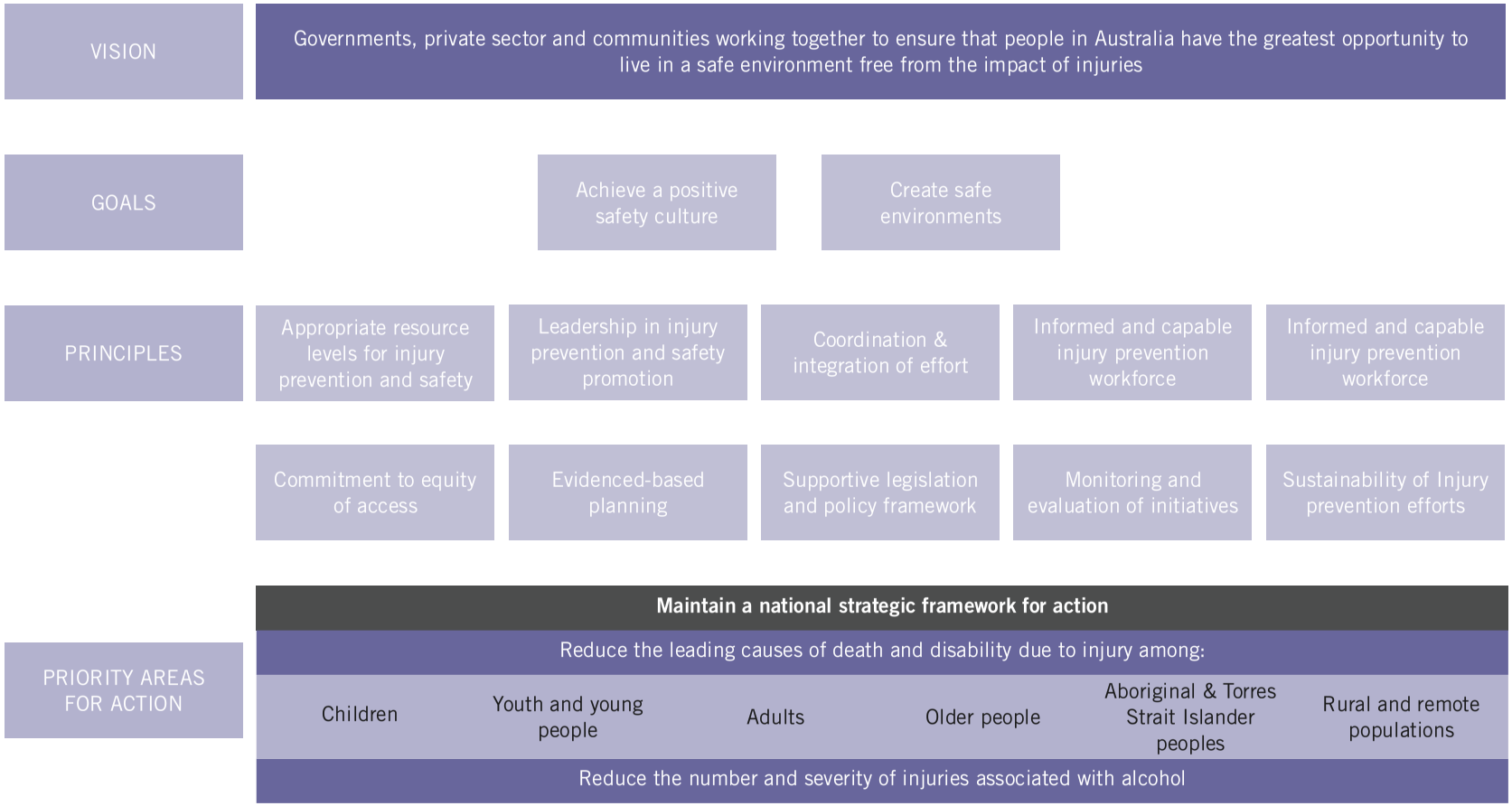
Some information on data, priorities and cross-cutting issues within this Plan have been drawn from the AIHW publication National Injury Prevention Plan priorities for 2004 and beyond: discussion paper (Pointer, Harrison and Bradley 2003), (*www.nisu.flinders.edu.au/pubs/reports/2003/injcat55.php*).

With the kind permission of the New Zealand Accident Compensation Corporation (ACC), this document draws heavily from the New Zealand Injury Prevention Strategy (October 2002), (*www.nzips.govt.nz*).

Some concepts have been adapted from the Canadian Injury Prevention Strategy detailed in the Canadian Collaborating Centers for Injury Prevention and Control report *Developing an integrated Canadian Injury Prevention Strategy*. (Canadian Collaborating Centers for Injury Prevention and Control 2003) (*www.injurypreventionstrategy.ca* accessed May 26, 2004).

SIPP also acknowledges the contributions of Jane Elkington and Kate Hunter of Jane Elkington & Associates and Jerry Moller of New Directions in Health and Safety in the development of this national plan.

Figure 1: Elements of the Australian Injury Prevention and Safety Promotion Plan



CONTENTS

OVERVIEW **2**
What is safety? 2
What is injury? 2
Preventing injuries 2
Achievements in reducing injuries in Australia 3
Vision 3
Goals 4
Who is the plan for? 5

CONTEXT OF THE PLAN **6**
Scope 6
Purpose of the Plan 6
How the Plan was developed 6
Links to other national injury prevention related strategies, plans and initiatives 7

DELIVERING THE PLAN **8**
Duration of the Plan 8
Health's role in leadership 8
Health's role in partnership 8
The role of non-health agencies 9
Implementation 9

CURRENT GAPS AND PRINCIPLES **10**
Current gaps that need to be resolved 10
Principles 10

AREAS FOR ACTION **12**
Maintenance of National Strategic Framework 12
Life stages 13
Special population groups 14
Alcohol 14
1. Establish and maintain a national strategic framework for the prevention of injuries and promotion of safety in Australia 15
2. Children 17
3. Youth and young adults 19
4. Adults 21
5. Older people 23
6. Rural and remote populations 25
7. Aboriginal and Torres Strait Islander peoples 27
8. Alcohol 29

APPENDICES **31**
Appendix A 31
Members of Strategic Injury Prevention Partnership (SIPP)
Appendix B 32
Links to other injury prevention related strategies, plans and initiatives
Appendix C 38
Data Issues

REFERENCE LIST **39**

OVERVIEW

This Plan encompasses the concepts of safety promotion and injury prevention. It examines unintentional injury, self-harm and harm to others.

What is safety?

In this Plan, safety is used to mean being at little or no risk of injury. A holistic approach to wellbeing requires that people must feel that they are safe in addition to actually being safe.

What is injury?

In public health practice, injury usually means physical harm to a person's body. Common types of physical injury are broken bones, cuts, brain damage, poisoning and burns.

Physical injury results from harmful contact between people and objects, substances, or other things in their surroundings. Examples are being struck by a car, cut by a knife, bitten by a dog, or poisoned by inhaled petrol.

Some physical injuries are the intended result of acts by people: harm of one person by another (assault, homicide etc.) or self-harm. Most injuries are not intended and these are often described as accidental.

Preventing injuries

Whether intended or accidental, most physical injuries can be prevented by identifying their causes and removing these, or reducing people's exposure to them.

The environments in which people live do much to determine injury risks and opportunities for injury prevention. The physical environment includes things such as roads, vehicles, buildings and the settings in which we live, work and play. These are often less safe than they could be, given better planning and design. Factors such as education, income and employment status comprise a socio-economic environment which shapes opportunities for and knowledge about safety. In addition, socio-cultural environments, which vary with gender, age and cultural background, influence choices that affect safety.

Lifestyles and behaviours also influence safety. They are shaped by attitudes and knowledge, and constrained by environmental factors.

Prevention of events likely to result in injury is usually the best approach. For example, risk of cars crashing is reduced by good road design and traffic control, by designing vehicles that are easy to control, and by ensuring that drivers are well-trained and sober. Barriers can reduce injury risk by keeping people away from hazards. For example, suitable pool fences and child-resistant closures on containers for poisons contribute to child safety.

The likelihood and severity of injury can also be reduced by safety devices such as seat belts, air bags and crumple zones in cars, helmets for cyclists, motorcyclists and people in certain jobs and sports, and various other types of personal protective equipment.

When serious injury occurs, the availability of good retrieval, acute care and rehabilitation services can increase chances of survival, and the speed and completeness of recovery.

Achievements in reducing injuries in Australia

Over recent years, Australia has achieved some significant gains in the prevention of a number of different types of injuries where concerted efforts have been made. There have been improvements in road safety over the past twenty-five years. The road toll in Australia has fallen from 3,578 (25.2 per 100,000 population) in 1977 to 1,715 (8.7 per 100,000 population) in 2002 (ATSB 2003). The reduction in road deaths has occurred despite significant growth in population, vehicle numbers and kilometres travelled. Initiatives such as random breath testing, compulsory seat belts, speed blitzes, car design and safety features (eg. air bags), better roads, ongoing community education regarding road safety, and improved life saving medical procedures and trauma care have all contributed to the decline in the number of vehicle-related fatalities.

Gains have also been made in the area of suicide prevention and poisoning in children. In the year 2000, the all-ages male death rate from suicide was 19.4 (per 100,000) compared with the 1997 rate of 23.4 per 100,000 (AIHW 2002). Hospital separation rates for poisoning in children aged 0-4 years have dropped from 302 per 100,000 in 1991-1992 to 267 per 100,000 in 1999-2000 (AIHW 2002).

Vision

The vision for the National Injury Prevention and Safety Promotion Plan is:

Governments, private sector and communities working together to ensure that people in Australia have the greatest opportunity to live in a safe environment free from the impact of injuries

This vision is practical and achievable yet challenging. It will act as a motivating force to stimulate and guide injury prevention and safety promotion efforts in Australia.

As we move toward this vision we will see:

- collaborative action by governments and communities to maximise the reach, efficiency and effectiveness of investments in injury prevention and reduce unnecessary duplication of services;
- a focus on those injuries with the greatest impact on individuals, families and communities. While acknowledging that minor injuries make up a large portion of the cost of injuries, by focusing on injuries that result in death and severe or lasting impact we will be emphasising the value placed on quality of life and independence;
- injuries being universally accepted as preventable by individuals, communities, health care workers, and policy makers, and across all settings (e.g. workplaces, schools, public places, residential settings, roads and sport and recreational environments).

Goals

To realise this vision we need to work strategically and collaboratively towards:

- achieving a positive safety culture; and
- creating safe environments.

A positive safety culture is a shared set of beliefs, attitudes, values and ways of behaving that support the prevention of injury. The goal of achieving a positive safety culture means that individuals, families, cultures, communities, organisations and governments all share the belief that injuries are preventable and investing in injury prevention and safety promotion is worthwhile. This is likely to be achieved through greater awareness of injuries and their prevention and greater commitment to sharing information, resources, funds and opportunities that will help reduce injuries. It will also be achieved through individuals recognising that they have an important role to play not only in preventing injuries to themselves but also to others in their family, with whom they work and play and for whom they provide services, and others in their own community.

This goal would see, for example:

- young people believing as passengers in a motor vehicle that they should speak out if they are uncomfortable with the way the driver is driving;
- general practitioners accepting that falls in older people are not inevitable and that they have a role in their prevention;
- culturally appropriate injury prevention and safety promotion resources are developed for culturally and linguistically diverse (CALD) communities; and
- workplace safety being embraced as a priority in all business planning.

Safe environments are the social and physical surroundings or conditions that support the prevention of injury. Creating safe environments means creating the socio-cultural circumstances in which people can feel safe as well as safer products, workplaces, roads, homes and public spaces, including sporting and recreational facilities. It also means providing opportunities for greater equity of access to these safer environments.

Where the commitment to safety is ideal, we might see for example:

- mandatory safety standards for baby products so that it is not only the expensive products that comply with safety recommendations;
- transportation alternatives in rural areas to enable young people to return home safely from weekend social activities;
- recreational facilities designed with a view to increasing opportunity for exercise for older people; and
- promotion of safe play areas on rural properties and restriction of access to hazards including dams and rivers.

Who the Plan is for

The Plan recognises that the health sector in each of the jurisdictions, whilst managing the consequences of all injuries, does not hold sole carriage for the prevention of those injuries. It acknowledges that the health sector will be able to play lead roles in some but not all injury prevention and safety promotion approaches. On issues led by other agencies – such as road safety, occupational health and safety and product safety – the health sector is a partner and has much to offer in terms of skills, models of practice, access to those at risk of injury, data and its analysis. The Plan therefore encourages strong partnerships in approaches to injury prevention and safety promotion.

The Plan will assist:

- **the health sector as a leader on injury prevention and safety promotion issues**
- **the health sector as a partner to other lead agencies on issues, and**
- **non-health agencies as partners with the health sector.**

The Plan encourages partnerships between key divisions within the health sector that have a role to play in the prevention of injuries, such as drug and alcohol, mental health, and physical activity divisions. The Plan also recognises the importance of partnerships between these divisions and key non-health agencies within government, the private sector and communities. It provides a framework for partners in injury prevention and safety promotion, to drive research, policy development and service delivery activities to achieve the areas for action listed in the Plan.

Some of the key divisions **within the health sector** that have significant roles in injury prevention and safety promotion are mental health, drug and alcohol services, children's services, Aboriginal and Torres Strait Islander health, rural health, clinical and emergency services and the various agencies with responsibility for research, policy and practice.

Partnerships in injury prevention planning between government agencies are encouraged in areas such as transport, occupational health and safety, local government, product safety, education, sport and recreation, veterans' affairs, housing, crime prevention and justice.

There are many **services and groups within the community** that have skills, credibility, reach and resources that contribute to safety promotion and are key partners in this area, for example: organisations involved in safety promotion; services for families, women, youth and older people; drug and alcohol services; cultural groups and church groups.

Partnerships with the **private sector** are instrumental to translating planning into action in safety promotion. Key elements within the private sector include designers, manufacturers, retailers, consumers, service delivery agencies, sporting and service clubs, employers and workers' unions.

It is envisaged that the Plan will encourage such organisations to further focus and coordinate their injury prevention and safety promotion efforts and resources by providing them with clear direction and priorities.

CONTEXT OF THE PLAN

Scope

The Plan has been developed to guide research and the development of programs and policies that will help prevent injuries.

The Plan recognises that needs and opportunities differ between jurisdictions, therefore it aims to have enough specificity to provide direction while encouraging flexibility within these areas to allow for the uptake of opportunities at national, state and local levels.

Purpose of the Plan

The purpose of the Plan is to establish a framework for the injury prevention and safety promotion activities of government agencies, local government, the private sector, non-government organisations, communities and individuals.

How the Plan was developed

The Plan is an initiative of the Strategic Injury Prevention Partnership. The Strategic Injury Prevention Partnership (SIPP) comprises injury prevention representatives from the health departments in all Australian states and territories as well as representatives from the Consumer Policy Division of Commonwealth Treasury, the Australian Institute of Health and Welfare and the Australian Injury Prevention Network. Appendix A presents a list of all the SIPP members (including the subcommittee overseeing the development of this document).

An evaluation of the *National Injury Prevention Plan: priorities for 2001-2003* and the *National Injury Prevention Plan: priorities for 2001-2003 Implementation Plan* was commissioned by SIPP as part of the process for developing the new National Injury Prevention and Safety Promotion Plan. Its evaluation indicated that the 2001-2003 plan was lacking in several areas including consultation during development and implementation, fostering and supporting of partnerships across sectors and between jurisdictions, resources, and that it was too narrowly focused. These concerns have been considered in the development of the current Plan.

There has been broad consultation, and efforts have been made to engage all sectors with an interest in preventing injury and promoting safety. It is envisaged that the implementation of this new Plan will further encourage partnerships in injury prevention and safety promotion. The life stages approach adopted in this Plan ensures it is of relevance to a broad range of groups.

A draft plan was developed under the guidance of the SIPP subcommittee. It was circulated widely for comment, with written responses being received from 36 agencies. Several of these submissions were from state and territory health departments that took responsibility for consulting widely at a state/territory-wide level and then developed a summary submission. The feedback from these submissions were summarised in an issues paper that was the subject of a national workshop held in November 2004. Twenty-five agencies were represented at this workshop. The comments from this workshop were used to further develop the Plan which was finalised by the SIPP subcommittee.

Links to other national injury prevention related strategies, plans and initiatives

A National Aboriginal and Torres Strait Islander Safety Promotion Strategy has been developed by the Aboriginal and Torres Strait Islander Injury Prevention Action Committee to complement this Plan and to examine the specific needs of Aboriginal and Torres Strait Islander peoples.

The Plan embraces a number of other national strategies, plans and initiatives dealing with specific injury areas that sit within the Plan's overall framework. These were identified during the development of this Plan, but are not inclusive. Others will also be developed during the lifetime of this Plan. The following national strategies, plans and initiatives were taken into consideration during the development of this Plan.

- Child Injury Prevention: A Kidsafe National Strategy
- National Alcohol Strategy
- National Drug Strategic Framework
- National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan
- National Falls Prevention for Older People Initiative
- National Life Framework
- National Mental Health Strategy
- National Occupational Health and Safety Strategy
- National Physical Activity Guidelines for Australians
- National Public Health Action Plan for Children
- National Road Safety Strategy
- National Strategic Framework for Aboriginal and Torres Strait Islander Health
- National Strategies of Farmsafe Australia
- National Strategy for an Ageing Australia
- National Suicide Prevention Strategy
- National Water Safety Plan
- National Youth Suicide Prevention Strategy
- Regional Health Strategy: more doctors, better services
- Rural Health Strategy

Many of these national strategies, plans and initiatives are described briefly in Appendix B.

DELIVERING THE PLAN

Duration of the Plan

The Plan has been developed to cover injury prevention and safety promotion activities for up to ten years. It may be amended earlier if necessary based on periodic assessment of progress. Specific actions, key agency roles and responsibilities, timeframes and performance indicators are found in the implementation planning documents that complement this Plan. An implementation strategy will form the basis of implementation activities and the workplans identified by SIPP.

Health's role in leadership

If this Plan is effective, the health sector's leadership role in injury prevention and safety promotion will be demonstrated through:

1. increased provision of quality data and its analysis to all sectors with a role in injury prevention and safety promotion to facilitate their planning processes;
2. encouragement of individuals and organisations in positions of influence within communities to give priority in their planning to the prevention of injuries;
3. greater collaboration with other disciplines and sectors to expand the reach of injury prevention and safety promotion opportunities, and avoid gaps and duplication of effort;
4. increased sharing of resources for and assistance in the evaluation of promising injury prevention and safety promotion activities;
5. advocating for increased resources for injury prevention and safety promotion in rural and remote communities and Aboriginal and Torres Strait Islander communities;
6. enhanced skills and resources within the health sector and its partners to address injuries.

The Australian Government Department of Health and Ageing in conjunction with the health departments of the states and territories and the Strategic Injury Prevention Partnership (SIPP) will take the lead on this Plan, its implementation and evaluation.

Health's role in partnership

This Plan will have succeeded if it also sees the health sector:

1. adopt a greater partnership role on initiatives and plans that have injury prevention and safety promotion as a key focus and can work collaboratively in the sharing of information, resources, and opportunities to prevent injuries (e.g. road safety, suicide prevention, occupational health and safety, product safety);
2. adopt a greater partnership role on initiatives and plans that have injury and safety as a sub-area of focus (e.g. drug and alcohol services, local government, youth services, police, housing); and
3. provide its partners with greater access to quality data on injury problems, research and skills, models of practice in injury prevention and safety promotion, access to some population groups of interest, and networks and communications channels for awareness raising and distributing resources.

The role of non-health agencies

If this Plan is effective it will also see other agencies, external to health, demonstrating:

1. greater awareness of injury issues in their sphere of influence;
2. greater involvement in partnerships promoting effective injury prevention and safety promotion strategies;
3. taking up opportunities to build their capacity to prevent injuries – through training at undergraduate and graduate levels, ongoing job skill development, networking, building information resources; and
4. devoting a greater portion of their business plans and budgets to safety promotion.

Implementation

The first implementation strategy will take effect from 1 July 2005. The Australian Government Department of Health and Ageing will work with government agencies to promote the Plan across government portfolio areas. A progress reporting process will be instigated to ensure that the Plan is being implemented as intended and to identify any areas of duplication or gaps. The Australian Government Department of Health and Ageing will also collect information, where appropriate, from other organisations and groups which help monitor progress towards the achievement of the Plan's objectives and actions.

A progress report on implementation of the Plan will be published by SIPP at approximately two-yearly intervals.

CURRENT GAPS AND PRINCIPLES

Current gaps that need to be resolved

There are a number of deficiencies in Australia's current injury prevention and safety promotion efforts.

- **Insufficient resourcing of injury prevention and safety promotion.** Investing in prevention is generally ranked a very low priority against treatment needs. Resourcing of injury prevention and safety promotion includes, but is not limited to, provision of (or support for): data collection and analyses; information and evaluation; access to communities; professional 'know-how'; and infrastructure and funding for the implementation of injury prevention and safety promotion initiatives.
- **Fragmentation of effort.** Given the wide range of agencies and organisations involved in injury prevention or safety promotion, it is necessary to ensure that messages are consistent and not unnecessarily duplicated. Injury prevention activity needs to be integrated through coordination and collaboration between government agencies and other organisations.
- **Gaps in injury prevention and safety promotion activity.** Some important injury issues have attracted insufficient attention relative to their impact.
- **Injury prevention workforce and safety promotion capability issues.** This workforce is diverse, often isolated and has limited access to training opportunities. Its capability needs to be enlarged and strengthened.
- **Quality of, access to, and dissemination of injury information.** There is a need for better, more accessible and improved dissemination of injury data and information to support injury prevention and safety promotion activity.
- **Limited understanding of effective injury prevention and safety promotion activities.** Australia has benefited from research in some areas of injury prevention and safety promotion such as road safety, but needs to expand such knowledge to many other injury areas through quality research and evaluation.

Principles

The Plan identifies ten principles for effective injury prevention and safety promotion.

1. **Appropriate resource levels for injury prevention and safety promotion.** Investment in injury prevention should adequately reflect that injury is a leading cause of death and disability in each of the identified priority population groups.
2. **Leadership in injury prevention and safety promotion.** The health sector has a lead role in supporting injury prevention through appropriate action in terms of advocacy, the provision of quality analysis of injury data, coordination, skill development and exemplary policies and standards.
3. **Coordination and integration of effort.** Collective action on injury prevention and safety promotion planning and activity is essential to close gaps and minimise duplication of effort. This requires the active participation of all levels of government, community groups, businesses, families and individuals working in partnership.
4. **Informed and capable injury prevention and safety promotion workforce.** Strategic planning at federal, state and local levels will ensure that individuals whose work context encompasses injury prevention and safety promotion are sufficiently informed and skilled to undertake best practice in the prevention of injuries.

5. **Access to quality data and its analysis**. The health sector has a major role to play in providing quality data and its analysis for use in injury prevention and safety promotion planning, monitoring and evaluation by its partners. Through the use of quality data and its analysis, programs can appropriately anticipate and respond to changes in injury patterns, exposure to risks and population trends.
6. **Commitment to equity of access**. Planning and delivery of injury prevention and safety promotion activities will aim to reduce inequalities in injury outcomes within and between groups, and to remove cultural and economic barriers to the uptake of interventions, by creating equity of access to information, services and products to those groups at greatest risk of injury.
7. **Evidence-based planning.** Injury prevention and safety promotion activity will be based on evidence of effective interventions and, where possible, good information about the political and social context in which interventions will be introduced.
8. **Supportive legislation and policy.** Sustainable changes in behaviour and the environment to reduce the risk of injury can be facilitated by supportive laws, policies and regulations operating at federal, state, local and community levels. Furthermore, supportive environments, created by policies and legislation, can on their own sometimes lead to behaviour change.
9. **Monitoring, research and evaluation of initiatives.** Identifying and implementing interventions that make the best use of resources (both organisational and financial) will be assisted by systems and infrastructure that ensure the ongoing monitoring and evaluation of interventions. Such systems should be designed to identify what works or what doesn't, the contextual factors that influence the uptake of interventions and outcomes, and emerging knowledge about proven or promising interventions.
10. **Sustainability of injury prevention and safety promotion initiatives.** Creating lasting change is most feasible if it is developed within the context of appropriate policies or legislation, the creation of safer products and environments, and the development and maintenance of intersectoral networks and sharing of resources and purpose.

AREAS FOR ACTION

The identification of areas for action in the Plan allows for flexibility in the choice of priorities and encourages greater development of partnerships in injury prevention and safety promotion.
The areas for action will be selected from a pragmatic planning perspective of:

1. **a general priority of developing the infrastructure** that allows all other planning to follow;
2. **a population approach** to planning based on a mix of 'life stages' and population groups of special interest; and
3. **one risk factor-based topic** – to highlight the cross-cutting issue of alcohol, and the need to address it to effectively reduce the size of the injury problem in Australia.

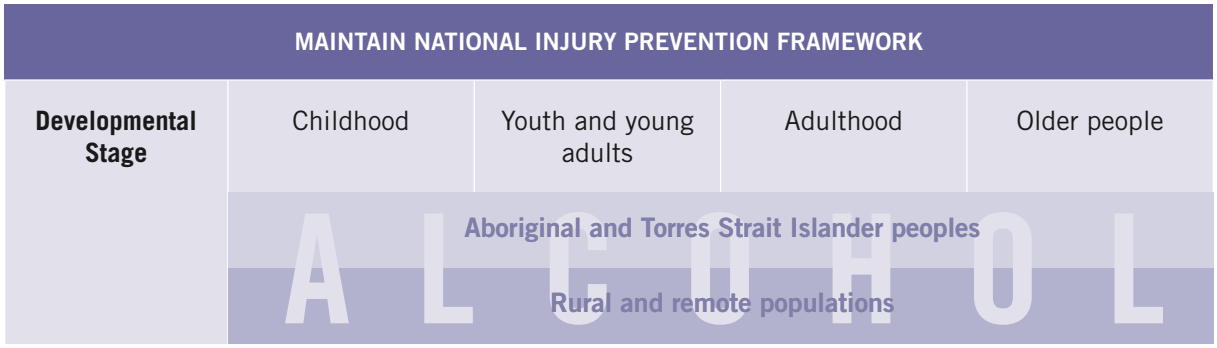
The areas for investment in injury prevention and safety promotion are:

- Maintenance of national strategic framework for action
- Children
- Youth and young adults
- Adults
- Older people
- Rural and remote populations
- Aboriginal and Torres Strait Islander peoples
- Alcohol.

Maintenance of National Strategic Framework

Figure 2, below, highlights the relationships between each of the areas for action.

Figure 2: Injury priority area across the developmental stages



Note: This figure is adapted from National Injury Prevention Plan Priorities for 2004 and beyond: discussion paper (Pointer, Harrison, & Bradley 2003).

The Plan adopts as the first area for action the development and maintenance of essential infrastructural support for collaborative, effective and efficient injury prevention and safety promotion planning. This area for action addresses the key gaps in practice to date and the principles of collaboration, evidenced-based planning with adequate resources and capacity for implementation, monitoring and evaluation. It also highlights the importance of addressing inequities created by socio-economic disadvantage, geographic, cultural or linguistic isolation.

By addressing these issues broadly and establishing a culture of collaborative partnerships in injury prevention and safety promotion this area for action will provide greater opportunities for effective progress in each of the other areas for action.

Life stages

The likelihood of being injured and the types of injury that are common differ between periods of life, reflecting people's changing capabilities, activities, circumstances and knowledge. Opportunities to influence safety – positively and negatively - also differ between stages of life.

Infants are dependent and vulnerable. Toddlers become capable of exploring their environment sooner than they acquire the knowledge and wisdom to recognise and avoid hazards, such as swimming pools. Older children explore a wider environment at school, sport and play. Injuries are common, but this is the stage of life at which fatal injury rates are lowest. Children are frequent road-users, especially as pedestrians and cyclists, becoming drivers of motor vehicles during later teen years. Use of alcohol and other drugs often commences during teen years.

The period from late teens to late twenties is the stage of life in which most people become independent of their parents, are finding work (risks of occupational injury tend to be high for young workers), forming a family of their own and establishing a home. This challenging period of life is associated with high rates of suicide (especially for males) and non-fatal self-harm (especially for females).

The next forty or so years is a stage of life in which adults are much engaged with the world in ways that shape their own risk of injury and that of other people. Adults are the great majority of drivers of motor vehicles and workers in paid employment. Adults are the people responsible for the safety of children, as parents, teachers and in other capacities. People in this stage of life are often the carers for ill and disabled people and for frail older people.

Older adults become more vulnerable to injuries due to declining strength and perception and increasing fragility. The impact of injuries tends to be high, reflecting lower recuperative capacity. While most older people live independent lives, many are dependent on other people, especially in the last stages of life.

A life stages approach to injury prevention recognises and responds to the differing injury risks confronting different age groups now, and the particular opportunities available to these groups to influence safety now and in the future. This approach recognises the value of seeing injury prevention as part of a comprehensive approach to enhancing health and quality of life.

Special population groups

As well as taking a life stages approach, the Plan identifies two special population groups as areas for action: Aboriginal and Torres Strait Islander peoples and rural and remote populations.

Identification of these two population groups does not negate the needs of other groups such as culturally and linguistically diverse (CALD) communities, males or lower socio-economic groups. Instead, the Plan hopes to provide 'models' of practice that can also be applied to other population subgroups of interest, and to provide a platform for the integration of these other groups.

Although the specific strategic requirements for improving the safety of Aboriginal and Torres Strait Islander people are being examined in the National Aboriginal and Torres Strait Islander Safety Promotion Strategy, this issue continues to require national attention.

Alcohol

The role alcohol plays in injuries cannot be ignored and requires specific attention. Identification of alcohol as an area for action enables a greater connection between the role of alcohol in the Australian culture and the relationship it has with injuries. The link between alcohol and violence, road trauma, self-harm, drowning, falls and even work-related injuries has been well established. Alcohol needs to be seen as a cross-cutting issue to be considered within the other areas for action.

The inclusion of alcohol as an area for action recognises this association and encourages partnerships within the health sector as well as with external agencies in government, the private sector and communities.

The data in this section has been provided by the National Injury Surveillance Unit, Australian Institute of Health and Welfare (November 2004). An overview of technical issues relating to the data can be found in Appendix C.

1. Establish and maintain a national strategic framework for the prevention of injuries and promotion of safety in Australia

Key issues and data

Injury occurs in many settings, and organisations and individuals in many sectors have knowledge, responsibilities and authority that can contribute to injury prevention and safety promotion. Effective implementation of this Plan requires leadership and partnership.

Plans for safety promotion and injury prevention have been developed for many sectors, such as road safety, occupational safety and product safety. Within the health sector, plans exist for the safety of therapeutic goods, suicide prevention and reduction of harm related to alcohol and other drugs. A national strategic framework for injury prevention and safety promotion in general complements these and encourages complementary and synergistic action. This supports government commitment to whole-of-government action and efficiency processes. A strategic framework may also identify gaps in coverage of existing plans.

This area for action will embody the principles of the Plan, particularly those concerning leadership and coordination, and highlights the need for injury prevention to take place within a climate of partnerships. Where appropriate, the health sector will take a lead role, and where it is not appropriate to lead, the health sector will work as a supportive partner with other agencies.

The infrastructure for safety promotion and injury prevention will be strengthened through implementation of this area for action.

Key data	Deaths (2002)			Hospital admissions (2001-02)		
	Males	Females	Persons	Males	Females	Persons*
Number of injury cases	5,271	2,549	7,820	190,870	126,471	317,347
As % of cases from all causes	8	4	6	7	4	5
As % of injury cases at all ages	100	100	100	100	100	100
Cases /100,000 population (age-adjusted rates)	56.5	23.3	39.4	1,983	1,239	1,624

* Includes missing and unspecified gender.

- Suicide (30%), unintentional injury related to transport (24%) and falls (19%) accounted for nearly three-quarters of injury deaths in Australia in 2002. Falls (35%) and transport-related injury (14%) were also common causes of injury cases admitted to hospital in 2001-02.
- Injury mortality rates have tended to decline during recent decades, though with fluctuations. Rates rose in the late 1990s and declined more recently. This was mainly due to variations in male suicide and unintentional drug-related deaths. The rate in 2002 was 13% less than the recent peak in 1999, and 7% less than the previous low point in 1995.
- The population-based rate of death due to unintentional falls has not changed greatly in recent years, but the number of deaths from this cause has increased because of growth in the older segment of the Australian population. This is likely to continue due to the further ageing of the Australian population, unless successful prevention substantially reduces the per capita risk of fall-related injury among older persons.

PRIORITY ACTIVITIES

- Appoint and support an appropriate group to monitor and review the National Injury Prevention and Safety Promotion Plan: 2004-2014.
- Define the injury problem for health and partners.
- Identify, engage, and collaborate with key groups (government, industry, community) involved in the prevention of injury in Australia.
- Provide quality data and its analyses.
- Advocate for greater attention to and greater resourcing of injury prevention and safety promotion.
- Create a cultural acceptance within the health sector and beyond that injuries are preventable.
- Raise the capacity of the injury prevention and safety promotion workforce and other sectors in their capacity to prevent injuries.
- Engage designers, manufacturers, retailers and consumers to increase their awareness of the role of safe design in injury prevention and safety promotion.
- Provide culturally acceptable injury prevention and safety promotion information and initiatives.
- Establish a communication strategy about the National Injury Prevention and Safety Promotion Plan: 2004-2014, its development and review.
- Establish an accessible collection of research and evaluated programs, resources, and policies that can help further planning in injury prevention and safety promotion.
- Develop and maintain a whole of government focus which supports a range of sustainable safety promotion and injury prevention programs and projects.

2. Children

Key issues and data

More than any other group, **infants, toddlers and young children** (ages 0-4 years) depend on others for their safety. Children become able to explore their surroundings before they gain knowledge and understanding of hazards and the skills to respond to risks. Preventing injuries among infants and toddlers depends on creating safer products and environments for them and on influencing those in our community who care for young children – notably parents, health care workers, and providers of child care and early education (preschool teachers). There is a need to focus on risks for serious injury and on the safety of environments frequented by children and the products to which they are exposed, especially including consumer products designed for child care and for use by children. Risk factors for childhood injury overlap with risk factors for other problems in childhood, and experiences in early childhood, such as living in a family or community that is greatly affected by alcohol, other drugs or violence, can influence safety and risk of injury later in life. A holistic approach to health, safety, security, education and welfare is needed for children and the families and communities in which they live.

Older children (ages 5-14 years) learn much about the world around them through observation and play. As they develop cognitively and physically their exposures to different settings broadens from the home, to child care or preschool, school, sporting environments, streets and neighbourhoods. Each setting presents its own hazards and risks of injury. Injury prevention should focus on preventing serious injury, tempering interventions with recognition of children's need for experiences and challenges that, among other benefits, can contribute to the development of positive risk management strategies. Older children begin increasing their independence from families and start to make safety judgements independent of their carers. They are on the verge of becoming motorists, paid workers, and users of alcohol and possibly other drugs. Primary influences remain parents, friends, the media and teachers at school.

Key data – children 0-14	Deaths (2002)			Hospital admissions (2001-02)		
	Males	Females	Persons	Males	Females	Persons
Number of injury cases	171	98	269	37,399	22,180	59,579
As % of cases from all causes in this age group	16	12	14*	12	10	11
As % of injury cases at all ages	3	4	3	20	18	19
Cases /100,000 population (age-adjusted rates)	8.2	4.9	6.6	1,829	1,142	1,494

* 3% before 1 year (when perinatal conditions are the most common cause of death), and 37% at ages 1 to 14 years.

- Over one-third of all deaths in Australia at ages 1-14 years are from injury. The most common case types are drowning (especially for toddlers), transport injuries (especially as pedestrians) and interpersonal violence (especially in infancy).
- About one in five people admitted to hospital due to injury in 2001-02 were children, in line with the proportion of children in Australia's population. Falls were the most common cause (43%). Transport accounts for fewer cases (14% of cases) but these tend to be severe. Burns (4% of cases) and assault (1% of cases) tend to result in relatively long stays in hospital. Poisoning is a common cause of injury admissions at ages 0-4 years (14%), though the period in hospital is usually brief.

- The special vulnerability of toddlers to injury is indicated by the prominence of drowning and pedestrian injuries in this age group. 'Home' is the most commonly recorded place of occurrence of injuries in this age group. Hazards arising in environments designed to meet the needs of older children and adults include unfenced swimming pools and vehicles with limited rear vision. Safety requires both passive measures, which automatically reduce risk, as well as education and behaviour change of children and adults.
- For older children, the prominence of injuries related to cycling and falls (especially from playground equipment at ages 5-9 years and from skateboards, in-line skates and similar conveyances at 10-14 years) reflects the exploratory and adventurous character of this stage of life.

PRIORITY ACTIVITIES

- Raise awareness of the leading causes of injury-related death and disability among children.
- Raise awareness of accidental injuries and abuse and neglect.
- Create cultural acceptance that injuries to children are largely preventable and that investing in prevention is worthwhile.
- Promote knowledge of child development among those who design, market and sell products for use by children or in places where children live or play.
- Ensure that planning for safety promotion among children considers the role of parents and carers, child care services, the education sector and sport and recreational organisations.
- Ensure the prevention of injuries in children is given an appropriate level of consideration in decision-making relative to legislation and standards for products and environments.
- Provide culturally appropriate and educationally relevant information to reach all communities, including low socio-economic status and culturally and linguistically diverse communities, and Aboriginal and Torres Strait Islander peoples about child safety promotion.
- Provide equity of access to health care and safe, quality child care.
- Provide safer products and environments for children that are appropriate to their age specific development.
- Provide information to communities, organisations, families and individuals that explains the size and nature of problems and solutions.

3. Youth and young adults

Key issues and data

Transition to adult activities, responsibilities and privileges tends to occur during the ten years or so from the middle-teens. This transition is reflected in rising rates of transport injuries and increasing proportions of deaths recorded as occurring outside the home, such as sports and athletic areas and work settings.

It is during the period of youth and young adulthood (defined here as ages 15-24 years) that most people at least begin to emerge from the family in which they spent their childhood, assuming more independent roles. In doing so, they are exposed to greater choices in life and greater opportunities for risk. New-found independence occurs simultaneously with the development of new skills (such as driving and job skills), with great need for acceptance by peers, and potential exposure to and experimentation with alcohol and other drugs, all of which can result in increased risks of injury. Changes are rapid and profound and result in a high rate of injury at all levels of severity.

The effects of serious injury at this stage in life can have long-lasting effects on social and emotional development and occupational roles. Effects may extend to people other than the injured young person. For example, the parents of a seriously injured young adult may resume a care-giving role.

Key data – young adults	Deaths (2002)			Hospital admissions (2001-02)		
	Males	Females	Persons	Males	Females	Persons
Number of injury cases	806	230	1,036	41,696	15,902	57,598
As % of cases from all causes in this age group	76	59	71	24	6	12
As % of injury cases at all ages	15	9	13	22	13	18
Cases /100,000 population (age-adjusted rates)	58	17	38	3,065	1,214	2,157

- Injuries were responsible for three-quarters of all male deaths at ages 15-24 years in 2002, and three-fifths of all female deaths. Nearly half of the injury deaths in this age group in 2002 were transport-related (mainly road crashes), and almost another third were due to suicide. The injury death rate was more than three times higher for young men than for young women. Involvement of alcohol was mentioned in 10% of injury deaths in this age group.
- Rates of death rose sharply from 15 years of age to a peak at about 18 years for transport-related deaths (male and female) and rose throughout the age range 15-24 years for male suicide. Trend data, however, indicate some fluctuations over time, with male suicide rates in this age group declining by about one-third from 1997 to 2002. Rates of transport-related death declined gradually for both sexes, as did female suicide rates. Deaths in this age group involving poisoning by narcotic drugs rose sharply from 1997 to 1999, before dropping back down by 2002 to rates lower than those in 1997.
- The rate of hospitalised injury for males at ages 15-24 years was 2.5 times the female rate in 2001-02. For young males, injury hospitalisation rates rose with age from a low in childhood to almost double by ages 20 to 24. Female rates varied much less with age from childhood into adulthood.

- Types of injury resulting in admission vary with age for both sexes. Falls were a common cause of admitted injury for young men (21% of cases), but at about half the rate for boys. The leading cause of injury admission for young women was intentional self-harm (22% of cases), which peaked at ages 15-19 years. The female rate for this cause was twice as high as the male rate. Among young men the most prominent causes of injury admission was transport-related injury (21% of cases and 35% of bed-days) followed by assault (13% of cases). The proportion of injury admission due to transport-related injury was similar for young women (21% of cases) but assault was less prominent (8% of cases).

PRIORITY ACTIVITIES

- Increase collaboration and coordination across sectors to reduce the impact of alcohol on injury occurrence.
- Provide information about injury prevention and safety promotion among young people to government sectors responsible for the safety and welfare of young people, such as police, education, community services and occupational health and safety.
- Advocate for investment in longitudinal, in-depth multi-disciplinary research that examines the interplay of risk factors that place young people, particularly young males at elevated risk of serious injury.
- Promote collaborative planning with all levels of government, private sector and communities to provide safer environments and encourage safer behaviour by young people at work, on the roads, participating in sport and recreational activities, and while celebrating.
- Ensure that interventions aimed at intentional and unintentional injuries among young people consider the role of alcohol.
- Actively seek the advice and participation of young people in developing and conducting strategies to prevent the leading causes of death and disability in their age group.
- Increase access to safer products and environments particularly regarding recreational facilities and transportation, with specific regard to disadvantaged young people in high risk settings and populations.

4. Adults

Key issues and data

For most people, adulthood is a period of active engagement in the world, as parents, workers, householders and in other ways. The exposure to risks in these settings is reflected in levels and patterns of injury, which include transport-related injuries and workplace injuries. Self-harm and injuries due to interpersonal violence are also prominent. Specific national plans focus on several of these types of injury.

The active engagement of adults also enables them to influence the safety and safety-related behaviour of other people. As parents of children and young people, adults can do much to provide safe environments and can model safety and risk management behaviours. As adult children of older parents, they can influence the lifestyle choices of older people.

Adulthood is also a period during which there is potential to anticipate and prepare for risks that emerge in later life. For example, exercise patterns established during adulthood may reduce risk of falling in later life, and plans can be made for suitable accommodation and living arrangements.

Key data - adults	Deaths (2002)			Hospital admissions (2001-02)		
	Males	Females	Persons	Males	Females	Persons
Number of injury cases	3,106	1,022	4,128	92,186	49,730	141,916
As % of all cause cases in this age group	20	11	17	7	3	5
As % of injury cases at all ages	59	40	53	48	39	45
Cases /100,000 population (age-adjusted rates)	59.7	19.4	39.5	1,779	954	1,365

- Common causes of fatal injury in this age range are suicide (42% of injury deaths in 2002), transport-related deaths (25%) and accidental poisoning by drugs (10%). Alcohol was recorded as being involved in 15% of injury deaths in this age group. Hospitalised injury cases in 2001-02 were commonly due to falls (23% of cases), transport-related injury (15%), intentional self-harm (10%) and interpersonal violence (9%). Sixteen per cent of male cases of fatal injuries and 4% of female cases were recorded as occurring while working for income.
- Patterns of injury vary with age during adulthood, which extends from one period at which injury rates are high (youth) to another (old age). Most of the main types of serious injury experienced by young adults (eg transport-related injury, self-harm, interpersonal violence) occur at much lower rates in middle age. Rates of most of these causes are much higher among young adult males than young adult females (hospitalised self-harm is the main exception), but male and female rates are more similar in middle age.
- Hospitalised falls show a more complex pattern. Relatively high rates for young men decrease with age to about age 50 years. Much lower rates for young women begin to rise with age after about 40 years of age and are similar to male rates in the 50-54 year age group. Rates for hospitalised falls for both sexes rise sharply at older ages. Rates of fall-related deaths begin a sharp age-related rise from about 60 years.

PRIORITY ACTIVITIES

- Support agencies responsible for the oversight of national strategies examining: occupational health and safety, suicide prevention, violence prevention, drug and alcohol harm minimisation, road safety.
- Link health promotion strategies targeting non injury issues with safety interventions where strategies are shared or complementary.
- Encourage injury prevention and safety promotion planning to consider the role of adults aged 25-64 as 'influencers' of other age groups at risk of injury.
- Ensure that programs and information targeting adults consider culturally and linguistically diverse (CALD) groups where many from this age group have limited literacy or English language skills.
- Incorporate adults as a key target group in other areas for action where they comprise a significant portion of the population group at risk, including alcohol, Aboriginal and Torres Strait Islander peoples, rural and remote populations.
- Consider working-aged adults in planning for the prevention of fall injuries among older people by creating lifestyle patterns and home environments that they will retain as they move into the later stages of life.
- Ensure that the place of adults is fully recognised in the role of families in providing support, care and direction for the prevention of violence, self-harm and unintentional injuries.

5. Older people

Key issues and data

Many older people lead long and active lives, free from serious injury, some remaining in the workforce long after common retirement age. As with other life stages, this is a period of transition. Unique to this transition is the potential for loss and decline. The loss of the support of spouse and friends, the movement of families away from their homes, and the decline of physical and mental abilities all affect the health and injury risks of this population. Ability to detect and react to danger slows, older bodies are less resilient and injuries have a greater impact. These changes influence the pattern of types of injuries experienced by older people. Fractures are common, often after falls that would not injure a young person. The impact of injuries on quality of life can be great, and injuries can necessitate sudden transition – often unwelcome – to a more dependent lifestyle.

The extent to which such changes become a problem and the age at which they emerge vary a good deal between individuals. For all older people, however, recognition of the implications of ageing for safety, and preparation for these, can do much to increase the chance of maintaining an independent, active and fulfilling life free from serious injury.

Key data – older people	Deaths (2002)			Hospital admissions (2001-02)		
	Males	Females	Persons	Males	Females	Persons
Number of injury cases	1,200	1,208	2,408	19,585	38,655	58,238
As % of all cases in this age group	2	2	2	2	4	3
As % of injury cases at all ages	23	47	31	10	31	18
Cases /100,000 population (age-adjusted rates)	120.7	76.3	94.9	1,922	2,631	2,358

- Rates of fatal and hospitalised injury rise with age after about 60 years of age, and peak from about 80 years.
- Although injury deaths are a small portion of total deaths for older adults, injury deaths in this age group make up about one-third of injury deaths at all ages. Injury deaths in older women account for nearly half of female injury deaths at all ages.
- The proportion of people aged 65 and older in the Australian population is projected to rise from 13% in 2002 to 27-30% in 2051 (ABS 2003). Thus, injuries in this age group will rise in terms of case numbers and the proportion of all injury.
- Falls were the main cause of injury deaths for older adults (55% of cases in 2002), followed by suicide (12% of cases) and transport (12% of cases). Males had higher rates than females for these three causes of injury deaths. Rates for fall injuries increased sharply with age. Rates of other causes of injury death, including suicide, also increased with age, but to a smaller extent than falls. Injury death rates for this age group declined a little from 1997 to 2002.
- Hospitalised injury amongst older adults during 2001-02 was largely due to falls (73% of cases and 82% of bed days). The proportion of injury deaths attributable to falls increased with age: 58% of injury deaths at ages 65- 74 years, 75% at ages 75-84 years and 86% at ages 85 years and older. Rates of injury admission due to falls were more than two and a half times higher for females than males. Transport-related injury (6% of cases) was the second most common reason for injury admission in this age range.

- The prominence of injuries related to falls highlights the importance of reducing the risk of falling (e.g. by suitable exercise) and the risk of serious injury when falls occur (e.g. by prevention and treatment of osteoporosis).
- Average length of stay in hospital rises with age for injuries due to causes such as falls and road traffic-related injuries, reflecting increased fragility.

PRIORITY ACTIVITIES

- Form a working group with representatives from national, state and territory health departments to develop a framework for collaborative action to prevent falls and fall-related injury.
- Form partnerships with the transport sector to reduce risks of motor vehicle crashes associated with loss of capacity and resilience.
- Improve equity of access and the attractiveness of exercise services to older people to increase opportunities for their participation in safe and regular exercise, particularly exercise that focuses on improving strength and balance.
- Work collaboratively within the community to develop systematic approaches to managing environmental risks in residences, public spaces and facilities.
- Develop and disseminate information to assist in the development of policies and programs to prevent injuries due to falls, transportation, and complications of surgical and medical care to older people in residential aged care and acute care and those living independently.
- Develop the capacity of health professionals and other service providers to older people to deal with falls prevention, commencing with raising their awareness of the preventability of falls and fall-related injuries and the resources and services available to promote falls prevention.
- Support the development of policies that prevent injuries due to falls among older people in acute care facilities, and among those older people living in residential aged care facilities and those living independently within the community.
- Control exposure to slipping and tripping hazards through the improved design and maintenance of environments, systems and products used by older people.
- Improve the design of aids and equipment such as hip protectors and walkers to increase acceptability and effectiveness.
- Ensure that programs and information targeting older people consider culturally and linguistically diverse groups where many from this age group have limited literacy or English language skills, taking into account expected changes over time in culturally and linguistically diverse groups for this age group.
- Encourage older people to develop a positive risk management strategy to prevent injury when making purchasing decisions.
- Encourage maintenance of safe independent living, including mobility for older people.
- Invest in evaluation of falls and falls-related injury prevention programs in order to expand understanding of best practice and most cost-effective practice in preventing falls-related injuries in older people.

6. Rural and remote populations

Key issues and data

Rural and remote areas of Australia are diverse, as are the settings in which people live, including regional centres, towns, small settlements, farms and remote communities. This segment of the Australian population is identified as an area for injury prevention action due to:

- the relatively high rates of serious injury among its residents; and
- special challenges for injury prevention in these areas.

High rates of injury: Rates of serious injury are higher for people living in rural and remote areas than for people living in major cities. The highest rates tend to occur among residents of the most remote areas. To some extent, the higher rates can be explained in terms of distance. For example, residents of farms and small, remote communities are likely to have more need to travel for long distances and at high speeds than urban residents. Risks also differ in other ways. For example, certain occupations known to present high risk of serious injury, notably farming and mining, are located mainly in rural and remote areas. However, more information is needed on patterns and causes of injury in remote and rural Australia. Distance and remoteness complicate rapid retrieval of injured people to acute care services, and may also complicate later stages of care and rehabilitation.

Challenges for injury prevention: In much of rural and remote Australia, relatively small populations are spread through large areas. This presents practical challenges for injury prevention. For example, a way to provide access to falls prevention exercise programs that is successful in a capital city might not be successful in a rural or remote area. Traditions of risk acceptance in some occupations may require special approaches.

Key data – Rural# and Remote*	Hospital admissions RURAL			Hospital admissions REMOTE		
	Males	Females	Persons	Males	Females	Persons
Number of injury cases	24,845	14,599	39,444	9,677	5,850	15,527
As % of cases from all causes in remote areas	8	4	6	12	7	9
As % of injury cases in all of Australia	13	12	12	5	5	5
Cases /100,000 population (age-adjusted rates)	2,498	1,452	1,999	3,521	2,486	3,046
Ratio of age-adjusted rates (Remote: Major Cities)	1.4	1.3	1.4	2.1	2.2	2.1

\# Defined as residents of Australian Standard Geographic Classification (ASGC) Remoteness zone 'Outer regional'

* Defined as residents of ASGC Remoteness zones 'Remote' and 'Very Remote'

- Residents of **rural** areas represented one in eight of all hospitalised injury cases in Australia during 2001-02. The rate of hospital admission due to injury was 1.4 times higher for rural residents than for city residents. Falls were the most common cause of injury hospitalisation, accounting for one-third of cases. Other common causes of injury hospitalisation were transport (16% of cases), assault (7% of cases) and intentional self-harm (5% of cases). Cases involving motorcycles and falls from animals (usually horses) and cases on farms were relatively prominent among hospitalised injury for residents of rural Australia.

- Residents of **remote** parts of Australia account for about one in twenty admissions to hospital due to injury. Rates of hospital admission due to injury were twice as high for residents of remote areas as for city residents in 2001-02. Falls were the most common cause of injury hospitalisation (22% of cases), followed closely by assault (21% of cases), transport-related injury (15% of cases) and intentional self-harm (4% of cases). Rates of admission due to assaults were much higher for residents of remote areas than for city residents, especially for females. Rates were particularly high for Aboriginal and Torres Strait Islander residents of remote areas.

PRIORITY ACTIVITIES

- Together with relevant partners focus attention on rural and remote issues in the development of injury data collection systems that will provide detailed data on injury types and severity and the identification of high-risk groups.
- Provide greater access to information and data that will aid the planning of injury prevention and safety promotion for rural and remote communities.
- Advocate for greater attention and greater resourcing to improve equity of access to safety in program funding for rural and remote communities, and to enhance access by rural and remote communities to safety information, skilled workforce, and safe transport options, workplaces, recreational and residential facilities.
- Raise awareness about the impact of road trauma, self-harm, violence, falls, farm-related injury and alcohol-related injury on rural and remote communities in Australia.
- Promote innovative environmental and product design to specifically target risk factors unique to rural and remote areas.
- Collaborate with key agencies and government bodies responsible for services and planning in rural and remote areas to ensure that the prevention of injuries is integral to planning and policy development.
- Advocate that government agencies with injury prevention and safety promotion responsibilities include injuries within rural and remote communities in their accountability documents and performance measures.
- Raise awareness of the challenges of program implementation and evaluation where populations are small and dispersed.

7. Aboriginal and Torres Strait Islander peoples

Key issues and data

Rates of serious and fatal injury are much higher for Aboriginal and Torres Strait Islander people than for other Australians, reflecting stressful circumstances of life and community problems experienced by many Aboriginal and Torres Strait Islander people.

Safety promotion and injury prevention have been a goal of activities in Aboriginal and Torres Strait Islander communities in some parts of Australia, for many years in some instances. Safety promotion or injury prevention has been the stated aim of some programs, while others have focused on issues such as family violence, or suicide and self-harm. State and National plans for Aboriginal and Torres Strait Islander safety promotion are now emerging. The National Aboriginal and Torres Strait Islander Safety Promotion Strategy, a companion to this document, is the first National plan on this topic.

Key data – Aboriginal and Torres Strait Islander peoples	Deaths (1997-2000)*			Hospital admissions (2000-01)**	
	Males	Females	Persons	Males	Females
Number of Indigenous injury cases	168	69	237	9,095	7,184
As % of all cause Indigenous cases	20	11	16	12	7
As % of all injury cases (whole population)	8	7	7	5	6
Indigenous cases /100,000 population (age-adjusted rates)	159	61	108	4,860	3,830
Ratio of age-adjusted rates (Indigenous: Other)	2.8	3.2	2.8	1.9	2.3

* Deaths data for Queensland, Northern Territory, Western Australia and South Australia. Annual average case numbers and rates during the four years from 1997 to 2000. From Helps & Harrison (2004).

** Source ABS/AIHW (2003)

- The injury death rate was 2.8 times higher for Aboriginal and Torres Strait Islander peoples than for other Australians in the period 1997 to 2000 (Helps & Harrison 2004), and the rate of injury hospitalisation in 1999-2000 was about twice as high (Lehoczky et al 2002).
- Intentional self-harm (suicide) and transport crashes were the most common causes of injury death for Aboriginal and Torres Strait Islander people, as in the rest of the population. The Aboriginal and Torres Strait Islander suicide rate was nearly twice as high as the rate for the rest of the population, and the transport injury death rate was nearly three times as high. The recorded rate of fatal homicides among Aboriginal and Torres Strait Islander males was over 7 times higher than the rate for other males, and the rate for females was over 11 times higher than the rate for other females.
- Recorded injury death rates were about twice as high for Aboriginal or Torres Strait Islander people who lived in remote areas as for those who lived in major cities. However, injury death rates for Aboriginal and Torres Strait Islander people were higher than those for other residents of each remoteness zone. Aboriginal and Torres Strait Islander injury death rates were particularly high in remote areas for transport crashes, suicide and homicide.
- In addition to high rates of injury, access to treatment is limited for many residents of remote areas. For example, of the 1,216 discrete Aboriginal and Torres Strait Islander communities surveyed in 2001, 78% were situated 50km or more from the nearest hospital (SIMC 2004).

- Assault was the most common cause of injury hospitalisation for Aboriginal and Torres Strait Islander people, making up about a quarter of all injury admissions, with rates about as high for females as for males (Lehoczky et al 2002). In contrast, assault accounted for about 5% of injury admissions for the total population in 1999-2000, with higher rates for males than females (Helps Cricks & Harrison 2002). In 2002, about 20% of Aboriginal and Torres Strait Islander people reported assault as a neighbourhood or community problem, and 11% had experienced abuse or violent crime in the preceding year (ABS 2004).
- Some stressors were particularly common for Aboriginal and Torres Strait Islander people living in remote areas, including abuse or violent crime (17%), witnessing violence (30%), overcrowded dwellings (42%), community problems of family violence (41%) and neighbourhood conflict (31%) and problems related to alcohol (54%) and illegal drugs (46%) (ABS 2004).

PRIORITY ACTIVITIES

- Build collaborative relationships for promoting safety and preventing injury within and between governments at all levels, and organisations and community groups that work with Aboriginal and Torres Strait Islander peoples, in order to collectively address injury.
- Stimulate national discussion on improving Aboriginal and Torres Strait Islander peoples' safety by encouraging Aboriginal and Torres Strait Islander community leaders to set safety promotion and injury prevention priorities, and by strengthening leadership and commitment.
- Increase knowledge and skills in and commitment to safety promotion and injury prevention in Aboriginal and Torres Strait Islander communities, among community leaders, and within the Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander workforce.
- Provide enough resources to build and enhance workforce capacity.
- Support safety promotion and injury prevention policies and strategies that address a mixture of social, environmental and behavioural factors, and provide good examples of dealing with the underlying alienation and disadvantage of Aboriginal and Torres Strait Islander peoples.
- Improve surveillance systems and other sources of quantitative and qualitative data, to provide adequate information for Aboriginal and Torres Strait Islander safety promotion and injury prevention. Develop mechanisms to coordinate injury prevention research and evaluation activities.
- Create and sustain local focus on promoting safety and preventing injury.
- Develop and maintain a whole-of-government focus that supports a range of sustainable programs and projects which promote safety and prevent injury.

8. Alcohol

Key issues and data

Alcohol is a major cause of mortality and morbidity in Australia, and injury is among the most important harmful consequences of alcohol consumption.

It has been estimated that during the ten years ending in 2001, approximately 1,100 injury deaths and 27,000 injury hospitalisations per year in Australia were due to alcohol. About half of the deaths involved road crashes, and one-quarter were suicides. Over one-quarter of the hospitalisations attributed to alcohol involved interpersonal violence (Chikritzhs et al 2003).

Risky use of alcohol is common in Australia. In 2001, 20% of persons at all ages, and 45% of those aged 18 to 24 years, reported drinking in excess of the NHMRC 2001 safe drinking guidelines for acute harm at least once a month (Chikritzhs et al. 2003).

Alcohol has been associated with raised risk of injury in many settings. In transport this includes driving motor vehicles, being a pedestrian and cycling. Alcohol has also been associated with injuries due to falls, fire, water-related recreation and sports, suicide and interpersonal violence (Chikritzhs et al. 2003, NHMRC 2001). The setting of drinking affects injury risk, as well as the quantity of alcohol consumed. For example, drinking in clubs and pubs is more strongly associated with violence than drinking in some other places.

The effect of alcohol on injury risk occurs mainly during the several hours after consumption, while ethanol is circulating in the blood. However, the hangover effects of recent high consumption may also raise risk, and long-term heavy consumption is a risk factor for suicidal behaviour.

The presence of alcohol in the body increases injury risk in several ways. It impairs coordination, reasoning and judgement, and slows reaction speeds. Alcohol weakens self-control, allowing people to say and do things that they probably would not do otherwise. This behavioural disinhibition, combined with reduced capacity to resolve inter-personal problems because of the effects of alcohol on reasoning and judgement, does much to explain how alcohol raises the risk of interpersonal violence.

Injury risk is raised for the person who has consumed alcohol and often also for others, such as people injured in a car crash that is caused by an alcohol-affected driver, or someone assaulted by a person who has been drinking.

Injury risk begins to increase at relatively low levels of alcohol intake. Injury risk is high for people who occasionally drink much more than their usual amount ('binge' drinking).

The vulnerability of young people to harmful consequences of alcohol consumption is heightened by their inexperience with the substance and its effects. In Australia, young people aged 15 to 24 years have been estimated to make up over half of serious road injuries due to alcohol and one-third of hospital admissions for alcohol-related violence (Chikritzhs & Pascal 2004).

Alcohol plays a significant role in injury in some population groups, particularly young people (especially young males); rural and remote populations and Aboriginal and Torres Strait Islander populations. Drinking by a relatively small proportion of people can have a great impact on a community. For example, two-thirds of Indigenous people aged 15 or over in remote parts of the Northern Territory report not drinking at all, yet 45% of respondents said that alcohol was a neighbourhood or community problem (ABS 2004b).

PRIORITY ACTIVITIES

- Support collaborative partnerships in research, policy and planning with agencies responsible for drug and alcohol issues, to ensure a better understanding of injuries associated with alcohol.
- Encourage injury prevention, safety promotion and alcohol researchers to consider the importance of the role of alcohol in injury risk.
- Support the development and maintenance of information on alcohol involvement in serious injuries.
- Advocate for opportunities to implement best practice in the prevention of injuries associated with alcohol on high-risk groups. High-risk groups include (but are not limited to) young males, Aboriginal and Torres Strait Islander communities and those at risk of self-harm.
- Take opportunities to resolve alcohol issues at all development stages and in each setting defined in this plan, including children.
- Expand understanding of best practice in the area of the prevention of injuries associated with alcohol by adequately resourcing, monitoring and evaluating programs.

APPENDICES

Appendix A

Members of Strategic Injury Prevention Partnership (SIPP)

Jurisdiction	Name	Position	Organisation
Co-Chair	**Professor Rod McClure**	Medical Epidemiologist, Medical School	Griffith University
Co-Chair	**Mr John Scott**	State Manager, Public Health Services	Queensland Health
Aust Govt	**Ms Rae Scott**	Director, Injury Prevention and Lifestyle Prescriptions Section	Department of Health and Ageing
TAS	**Mr Stan Bordeaux**	Injury Prevention Policy Officer, Population and Health Priorities	Department of Health and Human Services
ACT	**Ms Leah McKinnon**	Project Officer, Health Promotion Unit	ACT Health
AIHW	**Associate Professor James Harrison**	Director	AIHW National Injury Surveillance Unit
NSW	**Ms Pam Albany**	Manager, Injury Prevention Policy Branch	NSW Health
NSW	**Ms Rebecca Mitchell**	A/g Manager, Injury Prevention Policy Branch	NSW Health
SA	**Dr Ron Somers**	Injury Surveillance and Control Unit, Epidemiology Branch	SA Department of Health
QLD	**Mr Michael Tilse**	Manager, State Health Promotion Unit, Public Health Service	Queensland Health
VIC	**Ms Nicola Rabot**	Senior Project Manager, Injury Prevention, Public Health Group	Department of Human Services
NT	**Mr Steven Skov**	Community Physician, Centre for Disease Control	NT Department of Health and Community Services
WA	**Ms Nicole Bennett**	Injury Prevention Branch, Population Health Division	Department of Health
New Zealand	**Ms Sandy Brinsdon**	Portfolio Manager, Public Health Directorate	Ministry of Health, New Zealand
Aust Govt	**Mr John Wunsch**	Unit Manager, Consumer Safety Unit, Consumer Policy Division	Treasury
AIPN	**Mr Richard Franklin**	President	Australian Injury Prevention Network
SIPP Secretariat	**Annamaree Reisch**	Assistant Director	Department of Health and Ageing

Appendix B

Links to other injury prevention related strategies, plans and initiatives

The current Plan will need to be worked alongside several other national strategies or plans. Links to and an overview of these plans is provided below.

Child Injury Prevention: A Kidsafe National Strategy

www.kidsafe.com.au

Established in 1979, Kidsafe is a national charity organisation dedicated to the reduction of unacceptable risks that lead to unintentional childhood injury and death. The core Kidsafe National Child Injury Prevention Strategy is to continue to achieve a sustainable reduction in the number, severity and resulting disability of unintentional injury among children up to 15 years of age. The Strategy's components are to continue to advocate for legislative and environmental changes, promote and conduct education and awareness-raising activities, support relevant research, and provide child safety information and support services through active contact with all sectors of the community throughout Australia. Kidsafe actively develops ongoing partnerships with a variety of government and community organisations and focuses on key causes of severe injury and death.

National Alcohol Strategy

http://www.nationaldrugstrategy.gov.au/pdf/alcohol_strategy.pdf

The National Alcohol Strategy: A Plan for Action 2001 to 2003/04 was endorsed by the Ministerial Council on Drug Strategy in July 2001 to provide a national framework for action to reduce alcohol related harm in Australia. The National Alcohol Strategy is an initiative of the National Drug Strategy and was developed by the National Expert Advisory Committee on Alcohol.

National Drug Strategic Framework

http://www.nationaldrugstrategy.gov.au/framework/

The National Drug Strategic Framework provides a vision and direction for governments and non-government organisations in developing strategies and allocating resources for the prevention and reduction of the harmful effects of substance use on Australian society.

The principle of harm minimisation has formed the basis of the National Drug Strategy since 1985. Australia implements a comprehensive and balanced approach between the reduction of supply, demand and harm associated with the use of drugs across sectors and jurisdictions.

In November 1998, after extensive community, industry, government and non-government sector consultation, the National Drug Strategic Framework (NDSF) 1998-99 to 2003-2004 was endorsed. A new framework for the period 2004-2009 is currently under development.

National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2006

http://www.nationaldrugstrategy.gov.au/publications/framework.htm

The National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2006 was endorsed by the Ministerial Council on Drug Strategy on 1 August 2003 to help provide a nationally coordinated and integrated approach to reduce drug-related harm amongst Aboriginal and Torres Strait Islander peoples. Although implementation of priorities to be pursued under the Plan will largely be the role of jurisdictions, the Australian Government, through the Department of Health and Ageing, also has a role. This will take the form of coordination of effort at a national level and development of national programs to support jurisdictions.

The Ministerial Council on Drug Strategy endorsed the new National Drug Strategy: Australia's Integrated Framework 2004-2009, on 20 May 2004. The Council acknowledged that the development of the Complementary Action Plan was a significant outcome from the previous National Drug Strategy and identified the implementation of the Complementary Action Plan as a specific priority area for action under the National Drug Strategy 2004-2009.

National Falls Prevention for Older People Initiative

http://www.health.gov.au/pubhlth/strateg/injury/falls/index.htm

In the 1999-2000 Federal Budget, the Australian Government committed $6.6 million over four years towards the National Falls Prevention for Older People Initiative. This was extended for one year by an allocation of $2.2 million for 2003-04, giving a total budgeted amount of $8.8 for the five years. The Initiative also received an allocation of $9.5 million over four years in the 2004-05 Budget.

The Initiative aims to reduce the incidence, morbidity and mortality associated with falls among people aged 65 years and over in community, acute care and residential care settings.

National Life Framework

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-suicide-life

The LIFE Framework aims to foster strategic partnerships and position suicide prevention efforts across all sectors. It was developed by the National Advisory Council on Youth Suicide Prevention, and guided by consultation with key groups and evidence that suicide prevention requires a multi-faceted approach involving collaboration between all levels of government and the community.

The LIFE Framework consists of three companion documents: LIFE: Areas for Action, LIFE: Learnings about Suicide and LIFE: Building Partnerships.

National Mental Health Strategy

http://www.mentalhealth.gov.au/mhinfo/nmhs/index.htm

The National Mental Health Strategy is an agreement between the Commonwealth and all state and territory governments that aims to improve the lives of people with a mental illness. The Quality and Effectiveness Section of the Mental Health Branch within the Department of Health and Ageing is responsible for implementing a range of Strategy initiatives associated with information development, depression and suicide.

National Occupational Health and Safety Strategy

http://www.nohsc.gov.au/nationalstrategy/Strategy2sep.pdf

The National Occupational Health and Safety Strategy 2002-2012 is a landmark development signifying the commitment of all Australian governments, as well as the Australian Chamber of Commerce and Industry and the Australian Council of Trade Unions, to work cooperatively on national priorities for improving occupational health and safety and to achieve minimum national targets for reducing the incidence of workplace deaths and injuries. The Strategy was developed by the members of the National Occupational Health and Safety Commission (NOHSC) and reflects their agreement to share responsibility for continuously improving Australia's performance in work-related health and safety. It was endorsed by the Workplace Relations Ministers' Council May 2001.

National Physical Activity Guidelines for Australians

http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/phd-physical-activity-adults-pdf-cnt.htm

The National Physical Activity Guidelines for Australians provide a blueprint for promoting physical activity by building individual awareness of the benefits of small amounts of moderate-intensity physical exercise, and encouraging people to be healthier by being more active. The guidelines indicate that even people who are inactive or sedentary can gain health benefits through slight increases in physical activity.

The intent of the Guidelines is to offer guidance and options for moderate-intensity physical activity, which are both achievable and sustainable across gender, socio-economic and occupational groups. They refer to the minimum levels of physical activity required for good health. They are not intended for high-level fitness or sports training.

National Public Health Action Plan for Children

Currently under development.

National Road Safety Strategy

http://www.atsb.gov.au/road/nrss/index.cfm

The National Road Safety Strategy 2001-2010 was formally released by the Federal Minister for Transport, John Anderson in November 2000, and came into effect from January 2001. The target of the Strategy is to reduce Australia's road fatality rate per 100,000 population from 9.3 in 1999 to no more than 5.6 in 2010 – a 40% reduction.

National Strategic Framework for Aboriginal and Torres Strait Islander Health

http://www.health.gov.au/oatsih/pubs/healthstrategy.htm

The stated goal of this framework is 'To ensure that Aboriginal and Torres Strait Islander peoples enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice'. Aims and priorities are presented and 'key result areas' fall within three categories: "towards a more effective and responsive health system", "influencing the health impacts of the non-health sector" and "providing the infrastructure to improve health status".

National Strategies of Farmsafe Australia

http://www.farmsafe.org.au

Farmsafe Australia is the national association of agencies that have joined in addressing injury and illness associated with work and life on Australian farms. On-farm injury is associated with numerous hazards across a range of different commodity production systems. Farmsafe Australia has formed specific reference groups comprising practising farmers, government and experts in specific fields to develop national strategies to resolve or examine priority injury issues. These provide national direction for action in states and territories and within the different industry sectors, and have the endorsement of all member agencies, notably the National Farmers Federation and its member associations in all states and territories, and Commonwealth and state government agency members.

1. National Farm Machinery Safety Strategy 2000-2005

The National Farm Machinery Safety Strategy deals with injury associated with operation of mobile and fixed plant and smaller farm machines and equipment. The strategy has built on a previous program of work that resulted in reduction in tractor roll-over deaths through active partnerships between industry and state governments. Key priorities include machinery guarding and farm workshop safety.

2. Child Safety on Farms: A Framework for a National Strategy in Australia

The Child Safety on Farms Strategy acknowledges the unique dimensions associated with child safety in the farm environment. The Child Safety on Farms Strategy aims to reduce the incidence of injury and death of children aged 0-14 years on Australian farms.

3. Safe operation of All-terrain Vehicles and Utilities on Australian Farms - An Industry Strategy, 2004-2009

The All-terrain Vehicles and Utilities (ATV/ATU) safety strategy addresses the growing number of ATV deaths on Australian farms over the past decade. A multifaceted national strategy has been produced that will include development of safety guidelines for ATV/ATU operators, liaison with manufacturers over improved safety design and training and a national communication plan.

4. Industry-specific safety strategies

Production of different agricultural commodities poses different injury risk to different populations of workers, for example, the risks posed by harvesting and packing fruit are quite different from those posed by harvesting grain or cotton. Each major industry has worked to develop a national safety strategy and resource kit for injury risk management for producers.

National Strategy for an Ageing Australia

http://www.health.gov.au/budget2000/fact/acfact1.htm

There are now 2.3 million Australians aged 65 years and over representing 12% of the population. By 2016, this will increase to 3.6 million or 16% of the population.

The International Year of Older Persons and the Government provided $6 million over two years in the 1998-99 Federal Budget and a further $5 million in the 1999-2000 Budget to support a positive change in attitudes towards ageing and to enhance community recognition of the value of older Australians.

A whole-of-government approach to the issues will be facilitated. Positive attitudes towards older Australians will be encouraged and the benefits flowing from healthy lifestyles for older people will be highlighted. A further key element of the National Strategy for an Ageing Australia will be activities aimed at raising the profile of mature aged workers and their contribution to national economic growth.

National Suicide Prevention Strategy

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-suicide-overview

In the 1999-2000 Federal Budget, the Government committed $39.2 million over four years from July 1999 for a National Suicide Prevention Strategy (NSPS) to build on the former National Youth Suicide Prevention Strategy (NYSPS).

Local-level suicide prevention activities, support of community organisations and the development of community models of suicide prevention are priorities under the NSPS. The key outcomes of the NSPS are:

- support of national suicide prevention activities across the life span; and
- development and implementation of a strategic framework for a whole-of-government and whole-of-community approach to suicide prevention.

National Water Safety Plan

http://www.watersafety.com.au

The National Water Safety Plan (NWSP) 2004-2007 builds on the achievements of the inaugural water safety plan and was developed in consultation with the many and varied stakeholders with the goals of providing a coordinated and cooperative approach to Water Safety throughout Australia.

The National Water Safety Plan 2004-2007 aims to:

- identify, prioritise and benchmark the major water safety issues
- establish water safety standards and policies to be applied and monitored nationally
- improve the expertise, programs and resources that currently operate within the system
- maximise organisational linkages
- ensure that duplication of effort and resources are avoided
- ensure that positive ideas and best practice are shared throughout Australia

To achieve the aims, four key result areas have been highlighted; 1) water safety education, 2) water safety research, 3) aquatic locations, and 4) key demographics. There are 32 recommendations within these four areas.

National Youth Suicide Prevention Strategy

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/mental-suicide-youth

A total of $31 million was allocated over 1995-99 for the National Youth Suicide Prevention Strategy. Underpinning the strategy is the premise that suicide is a complex problem that must be dealt with using a range of approaches. The four goals of the strategy are:

- prevent premature death from suicide among young people
- reduce rates of injury and self-harm
- reduce the incidence and prevalence of suicidal ideation and behaviour
- enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.

Regional Health Strategy: more doctors, better services

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-budget2000-fact-ruralfact3.htm

Components of the Regional Health Strategy are mutually reinforcing. They work together to increase the availability and viability of rural health services for the long term. Fifteen points are presented to deal with the provision of health services to rural Australia.

Rural Health Strategy

http://www.ruralhealth.gov.au/

Building on the achievements of the Regional Health Strategy announced in the 2000-01 Budget, the Rural Health Strategy will fund a range of initiatives including rural health services, programs to support the recruitment and retention of general practitioners and long-term measures to increase the rural workforce. The Rural Health Strategy will also focus on new preventive health measures to close the gap in health outcomes between rural and urban Australians. The 2004 Rural Health Strategy provides $830.2 million over four years for a flexible package of health and aged care services and workforce measures.

Appendix C

Data Issues

Except where another source is given, statistical information in this document was provided by the AIHW National Injury Surveillance Unit. Unless stated otherwise, rates are estimated annual incidence rates per 100,000 population, standardized by the direct method using the Australian mid-year population in 2001 as the reference.

Deaths: All deaths registered in Australia during calendar year 2002 that were given an underlying cause of death code in the range ICD-10 V01 to Y98. Data source: Australian Bureau of Statistics.

Hospitalised injury: Episodes in hospitals (public and private) in Australia which ended during the year to 30 June 2002, and had as the principal diagnosis an ICD-10-AM code in the range S00-T79. Some injuries result in more than one episode in hospital. Approximate allowance was made for multiple counting of these cases by omitting records in which separation was to another acute hospital, or was a statistical separation. (Available national data did not enable accounting for multiple separations at case-level.) Data source: AIHW National Hospital Morbidity Database.

Data for Aboriginal and Torres Strait Islander peoples: The quality of death, hospital and population data on Aboriginal and Torres Strait Islander people differs between states and territories and over time, complicating meaningful reporting for Australia as a whole, and small case numbers limit reporting for individual jurisdictions. Mortality information reported in this document is for the four jurisdictions in which Aboriginal and Torres Strait Islander data was thought to be relatively complete: Western Australia, South Australia, Queensland and the Northern Territory (Helps & Harrison 2004). Deaths registered in the four years 1997 to 2000 were combined because of small case numbers.

The hospital admissions data for topic 7 (Aboriginal and Torres Strait Islander peoples) were derived from Table 7.20 of *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2003* (ABS/AIHW 2003). This information is not directly comparable with other hospital data in this document.

REFERENCE LIST

Australian Bureau of Statistics (ABS) 2003. Population projections, Australia. Cat. no. 3222.0. Canberra: ABS.

Australian Bureau of Statistics (ABS) 2004. National Aboriginal and Torres Strait Islander Social Survey 2002. Canberra: ABS.

Australian Bureau of Statistics (ABS) 2004b. National Aboriginal and Torres Strait Islander Social Survey 2002—Northern Territory. Canberra: ABS.

Australian Bureau of Statistics (ABS)/Australian Institute of Health and Welfare (AIHW) (2003) The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2003. Canberra: Australian Bureau of Statistics and Australian Institute of Health and Welfare

Australian Institute of Health and Welfare (AIHW) 2002. Australia's health 2002. Canberra: AIHW.

Australian Transport Council 2000. The National Road Safety Strategy 2001-2010. Canberra: Australian Transport Safety Bureau.

Australian Transport Safety Bureau (ATSB) 2003. Road crash data and rates. Australian states and territories 1925 to 2002. Canberra: ATSB.

Australian Water Safety Council 2004. National Water Safety Plan 2004-2007. Sydney: Royal Life Saving Society Australia.

Canadian Collaborating Centers for Injury Prevention and Control 2003. Developing an integrated Canadian Injury prevention strategy. Canada: Canadian Collaborating Centers for Injury Prevention and Control.

Chikritzhs T & Pascal R 2004. Trends in youth alcohol consumption and related harm in Australian jurisdictions, 1990–2002. National Alcohol Indicators Bulletin no. 6 November 2004. Perth: National Drug Research Unit, Curtin University.

Chikritzhs T et al. (Need to list remaining authors for this report and delete the et al.) 2003. Australian alcohol indicators, 1990–2001. Perth: National Drug Research Unit, Curtin University.

Chikritzhs, T., Catalano, P., Stockwell, T.R., Donath, S., Ngo, H.T., Young, D.J. and Matthews, S 2003. Australian Alcohol Indicators, 1990-2001; patterns of alcohol use and related harms for Australian states and territories. Perth: National Drug Research Institute and Turning Point Alcohol and Drug Centre Inc., National Drug Research Institute.

Commonwealth of Australia 1998. The National Mental Health Strategy. Canberra: Commonwealth Department of Health and Aged Care.

Commonwealth of Australia 1999. National Physical Activity Guidelines for Australians. Canberra: Commonwealth Department of Health and Aged Care.

Commonwealth of Australia 1999. The National Strategy for an Ageing Australia. Canberra: Commonwealth Department of Health and Aged Care.

Commonwealth of Australia 2000. More doctors, better services: regional health strategy. Canberra: Department of Health and Aged Care.

Commonwealth of Australia 2000. National Framework Life 2000. Canberra: Commonwealth Department of Health and Aged Care.

Helps Y, Cripps R & Harrison J 2002. Hospital separations due to injury and poisoning, Australia 1999–00. Cat. no. INJCAT 48. Adelaide: AIHW.

Helps YL & Harrison JE 2004. Reported injury mortality of Aboriginal and Torres Strait Islander people in Australia, 1997–00. Canberra: AIHW.

Lehoczky S, Isaacs J, Grayson N & Hargreaves J 2002. Hospital statistics. Aboriginal and Torres Strait Islander Australians 1999–2000. Occasional paper. Canberra: ABS.

Ministerial Council on Drug Strategy 1998. The National Drug Strategic Framework 1998-1999 to 2002-2003 Building Partnerships. Canberra: Commonwealth Department of Health and Aged Care.

Ministerial Council on Drug Strategy 2001. National Alcohol Strategy: a plan for action 2001 to 2003–2004. Canberra: Commonwealth Department of Health and Aged Care.

Ministerial Council on Drug Strategy 2003. National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2006. Canberra: Australian Government Department of Health and Ageing.

National Aboriginal and Torres Strait Islander Health Council (Australia) 2004. National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for action by Governments, Canberra: Australian Government Department of Health and Ageing.

National Alcohol Strategy 2003. Alcohol and your health Factsheets. Alcohol and injury. Fact sheet 14. Canberra: Commonwealth Department of Health and Ageing.

National Health and Medical Research Council (NHMRC) 2001. Australian alcohol guidelines: health risks and benefits. Canberra: NHMRC.

New Zealand Accident Compensation Corporation 2002. New Zealand Injury Prevention Strategy. Wellington: Accident Compensation Corporation.

Pointer S, Harrison J and Bradley C 2003. National Injury Prevention Plan priorities for 2004 and beyond: discussion paper. Injury Research and Statistics Series No. 18. Cat. no. INJCAT 55. Adelaide: AIHW.

Statistical Information Management Committee (SIMC) 2004. National summary of the 2001 and 2002 jurisdictional reports against the Aboriginal and Torres Strait Islander health performance indicators. Cat. no. IHW 12. Canberra: Statistical Information Management Committee, AIHW.