

# Round Table Report

CONSULTATION TO DEVELOP A NATIONAL INJURY PREVENTION  
STRATEGY IN AUSTRALIA

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## Acronyms

CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
ICD	International Classification of Diseases
LGA	Local government area
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex or questioning
LHN	Local Health Network
MOU	Memorandum of understanding
NGOs	Non-governmental organisations
PHN	Primary Health Network
PTSD	Post-traumatic stress disorder
SES	Socioeconomic status

## Introduction

In the 2018-19 Commonwealth budget, the Australian Government committed to developing a National Injury Prevention Strategy in recognition of the ongoing and substantial burden of injury and following expiration of the previous National Injury Prevention and Safety Promotion Action Plan (2004-2014).

In March 2019, The George Institute for Global Health was appointed to facilitate and write the Australian National Injury Prevention Strategy (the Strategy). To begin the important process of consultation, the Australian Government Department of Health convened two Round Table discussions. Key stakeholders (representatives from Government and non-government organisations, community controlled organisation and peak bodies) were invited to attend one of two Round Tables held in Sydney on March 18 and Melbourne on March 26 (see Appendix A for delegate information). The Round Tables were held at Rydges Central (Sydney) and Rydges Melbourne.

This report is a summary of the Round Tables and includes an overview of the attendees, a summary of key issues discussed at both Round Tables and presents points for further consideration as posed by the delegates. It combines input from both Round Tables and where relevant, highlights points of difference.

This document has been prepared as an internal document for the Australian Government Department of Health and will be used to inform the Expert Advisory Group tasked with developing the Strategy.

## Round Table Agenda

- ▶ Welcome to Country
- ▶ Video of welcome from Minister Hunt
- ▶ Opening Address - Australian Government Department of Health
- ▶ Presentation by the Australian Institute of Health and Welfare (AIHW) on the injury burden in Australia
- ▶ Presentation by Kate Hunter from the George Institute for Global Health on the Literature Review and review of existing strategies
- ▶ Small group discussion on the guiding principles identified by the Literature Review for the Strategy followed by a vote and discussion
- ▶ Small group discussion on priority setting for the Strategy followed by a vote and discussion
- ▶ Small group discussion to develop priority actions
- ▶ Closing summary and next steps

The key difference between the Sydney and Melbourne Round Tables was that the Sydney Round Table included discussion around the strengths and weaknesses (in the Australian context) of framework elements drawn from other national and international strategies. Whereas in Melbourne this discussion was combined with the discussion of the guiding principles and priority setting.

External consultants were appointed to facilitate each day: Professor Niki Ellis of N E & A facilitated the Sydney Round Table and Mr Andrew Hollo of Workwell Consulting facilitated the Melbourne Round Table.



## Objectives

The objectives for the Round Tables were to:

1. Gain an understanding of stakeholder perspectives on the development of a national strategy for injury prevention.
2. Test and add to information already gathered on the current state in relation to the health burden arising from injury, and relative effectiveness of interventions.
3. Obtain input on and support for a national strategy for injury prevention.

## Welcome to Country

The Welcome to Country was delivered by Mr Craig Madden from the Metropolitan Local Aboriginal Land Council (Sydney Round Table) on behalf of the Gadigal people of the Eora Nation and by Wurundjeri Elder Uncle Ron Jones from Wurundjeri, Woi-wurrung Cultural Heritage Aboriginal Corporation (Melbourne Round Table) on behalf of the Wurundjeri people of the Kulin Nation.

## Opening video – Minister Hunt

The video was played at both Round Tables. In the opening remarks, Minister Hunt thanked the delegates and acknowledged their work in injury prevention. He highlighted the burden of injury; that it is the leading cause of death among Australians aged between one and forty four years. Minister Hunt said that these Round Tables were the beginning of the process of developing the Strategy to make a “massive and profound difference”. He called on delegates to have input to develop the “best, most desirable Strategy to ... achieve outcomes”. The Minister concluded by wishing delegates the best in their deliberations on the day and moving forward in drafting the National Injury Prevention Strategy.

## Introduction by Australian Government Department of Health

Ms Tiali Goodchild (Assistant Secretary - Preventive Health Policy Branch, Population Health and Sport Division) delivered the opening address in Sydney and Mr Alan Philp (Director, Preventive Policy Section – Preventive Health Policy Branch) in Melbourne. Both speakers welcomed delegates, thanked them for their input and commitment to injury prevention and challenged the delegates to identify the key messages to take back to government regarding how to make a National Injury Prevention Strategy save lives and make a difference. The Strategy will cover the whole population with a focus on children and Aboriginal and Torres Strait Islander people.

## Presentation by AIHW/NISU – burden of injury

The presentation on the burden of injury was developed by Prof James Harrison. Clara Jellie delivered the presentation in Sydney and James Harrison delivered the Melbourne presentation. Clara Jellie heads up the Medical, Dental and Pharmaceutical Unit at the Australian Institute of Health and Welfare (AIHW), and as part of this role manages the AIHW’s injury work program, which is delivered by the National Injury Surveillance Unit (NISU) based at Flinders University (headed by Professor James Harrison). James Harrison is an injury epidemiologist and

public health physician who directs the AIHW National Injury Surveillance Unit and leads injury research at Flinders University. He studies injury, its burden, determinants and outcomes. All delegates received a hard copy of the AIHW/NISU presentation.

Essentially, the presentation addressed the:

- ▶ Long-term disability associated with injury;
- ▶ Current plateauing of injury deaths and rising injury hospitalisations;
- ▶ Inequities associated with injury;
- ▶ Association of injury and age;
- ▶ Diverse nature of injury;
- ▶ 'Blinkers and blind spots' in injury data; and,
- ▶ Potential improvement with effective injury prevention programs and initiatives.

## Discussion following presentation by AIHW/NISU

The questions and comments arising from the AIHW/NISU presentation covered the following key areas:

- ▶ Data (and priorities that may follow from the data) should not only reflect major injury types but also risk factors such as alcohol and other drugs, or sleep problems.
- ▶ Need for quality data that is timely and reflects, where possible, exposure levels among different population groups, and the burden of injury in terms of fatalities and disability / morbidity.
- ▶ Need to have the capacity to link data in a timely way.
- ▶ Need to link data relating to the environment with potential impact on exposure and consequent injury outcomes. The example provided was that changes in the built environment may impact people's exposure to bicycle riding.

## Presentation on preliminary findings of the Literature Review

Dr Kate Hunter, Senior Research Fellow with the Injury Division of The George Institute for Global Health, presented on behalf of a team of injury researchers working on a review of the literature for the Strategy. The presentation included:

- ▶ Commentary on the process of selecting and identifying priorities in injury prevention, citing work recently completed in British Columbia regarding setting injury prevention priorities was cited. This included consideration of the importance of the issue, the modifiability of the

issue, the potential for acceptance of a proposed intervention, the feasibility of the intervention and its evaluability;<sup>1</sup>

- ▶ Preliminary results from a review of systematic reviews of injury prevention interventions for each of the key injury areas;
- ▶ Overview of the gaps in the current literature;
- ▶ Overview of guiding principles of other related strategies;
- ▶ Overview of the core elements of past and present national and international injury prevention strategies.

## Discussion following presentation on the review of the literature

- ▶ The importance of keeping broader social issues in mind with actions and priorities was highlighted – not just the immediate risk factors.
- ▶ It was acknowledged that there are significant gaps in available evidence on implementation and that this needs to be addressed via greater resourcing of implementation research via targeted calls and identified priorities for example through the National Health and Medical Research Council's grant program (NHMRC), and attention to levers (perhaps borrowing from lessons from other areas – like alcohol and taxation policies).
- ▶ Emphasis on ownership of the Strategy and ongoing connections between stakeholders to have it translate into action.
- ▶ Focus on translational research – build into the Strategy how we translate evidence into policy and practice and how we achieve multi-sectoral involvement.
- ▶ Data issues - measurement of the burden needs to include longer - term impact (not just hospital separations, but the impact on residential care numbers and costs for example due to falls in older people in that sector. This speaks to the importance of keeping high cost injuries (like falls in older people) on the priority list.
- ▶ Need for attention to planning for increase in frequency of extremes of weather and its impact on injuries, and further research in this area.
- ▶ The role of sleep and sleep quality, deprivation and consequent potential for targeted interventions need to be investigated.
- ▶ The lack of evidence of effective interventions targeting young people and young adults was noted.

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<sup>1</sup> Oakey M and the BC Injury Research and Prevention Unit. Provincial Injury Prevention Priorities. Report of the BC Injury Prevention Committee. July 2017.

# Discussion of guiding principles for the national strategy

## Strengths and weaknesses of framework elements

Participants discussed the guiding principles identified by the literature review. A hard copy of these was provided on tables. Each group considered the full set of principles. Scribes recorded comments. The notes below reflect a summary of these comments under each of the principles considered, combining issues raised at both Sydney and Melbourne workshops.

## Overall discussion

- ▶ The Strategy needs to have specific, action-oriented targets and timelines.
- ▶ There should be a focus on building strength/capacity of communities.
- ▶ Ensure the language is straight forward – free of jargon and empty phrases.
- ▶ There is a danger of this not translating to action.
- ▶ Action needs to include specifics about resourcing and infrastructure development, indicating government commitment to these.
- ▶ Engage/consult with a wide cross section of stakeholders including local government and emergency services.
- ▶ Focus needs to be on sustainable change.

## Principles

### 1. Coordination

- ▶ Discussion emphasised the need for whole of government coordination or 'partnership' which is long-term (not short-term/election-length planning).
- ▶ Accountability and other aspects of governance should be embedded in the Strategy.
- ▶ Recommendations included that the federal government/Health Minister's portfolio needs to implement the coordination, state and federal differences need to be understood, and a Memorandum of Understanding (MOU) should be developed for all government agencies to work together on injury.
- ▶ Additional viewpoints included that there needs to be greater attention and resourcing of local/community agencies and greater

coordination of their efforts, and specific roles identified for all who may contribute to actioning the Strategy, e.g. teachers, police.

- ▶ There needs to be coordination of data collection from different agencies.

#### 4. Resourcing

- ▶ There was strong support for this being the most critical element and that the challenges facing government in not resourcing the Strategy appropriately should be addressed. One such challenge identified was that the Australian Charities and Not-for-profits Commission does not recognise injury for Public Benevolent Institution status because it is not a 'chronic disease' – this can be fixed.
- ▶ Commitment to greater resourcing would follow better data on the true cost of injury, including long-term costs and those costs borne beyond the health care sector. The costs of not acting need to be identified and thus the cost: benefit of investing in injury prevention. Evidence from other countries could assist here.
- ▶ Resources needed include an informed and capable injury prevention workforce – this should be identified as a responsibility of all sectors.

#### 5. Approach

- ▶ Suggestions for clarification of this term were raised.
- ▶ Approaches that were put forward included holistic, evidence-based, dynamic and responsive to the needs of the community and a life-course approach – such as early intervention to address the risk factors for violence (low socio-economic status, alcohol abuse, intolerance).
- ▶ Human rights approach, e.g. children, people from minority groups.
- ▶ Others included tangibility (translation to tangible outcomes), and visibility to engender support from the wider community.

#### 6. Commitment to equity of access

- ▶ Sydney delegates raised that it should just be “commitment to equity” as it is about more than access (includes implementation, impact and outcomes) and this should be a leading principle and included in indicators of the Strategy progress.
- ▶ Considerations of whole-of-life, culture-specific and person-centred planning to address equity.

- ▶ Equity for children means addressing parenting, and the importance of families gaining consistent support from other organisations (beside health), particularly in early intervention.
- ▶ Should include culturally and linguistically diverse people and refugee populations.
- ▶ This principle has cross-over with others, e.g. human rights priority includes Aboriginal and Torres Strait Islander people, which requires collaboration and should be resourced appropriately.
- ▶ Empowerment through training and collaboration.

## 7. Implementation and evaluation

- ▶ Innovation should be encouraged alongside evaluation.
- ▶ It is important to identify what is important to the community, from the community's perspective: attitudes to injury prevention, motivations to change.
- ▶ This principle is also linked with “community control, empowerment and engagement”.
- ▶ Focus on evidence-based implementation and creating evidence - which require sharing this information and access to timely data.
- ▶ Strong evaluation designs should be resourced including cost-benefit analysis to guide better investment decisions.
- ▶ The community needs to be consulted and involved in community-led interventions.

## SLIDO findings

Based on the review of related strategies, a list of guiding principles were uploaded to SLIDO. SLIDO is an audience interaction tool. Individuals ranked the importance of each principle via SLIDO.<sup>2</sup> The use of SLIDO during the Round Tables was to facilitate live polling to determine group attitudes. The group was asked the following question “what are the most important (top 5) guiding principles that you think should guide the National Injury Prevention Strategy?” Participants were also able to write in their own guiding principles.

The top five principles among the participants at the Sydney Round Table were:

1. Effective implementation, monitoring and evaluation 53%
2. Whole of government approach – integrated 49%
3. Cross-sectoral collaboration (public, private, non-profit, community) 44%
4. Appropriate resource levels for injury prevention and safety 31%
5. Dynamic – continuously monitor, evaluate and improve 29%

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<sup>2</sup> <https://www.sli.do/>

The top five principles among the participants at the Melbourne Round Table were:

1. Long-term cross-sectoral collaboration (public, private, non-profit, community) (64%)
2. Long-term whole of government commitment – integrated (52%)
3. Appropriate resource levels for injury prevention and safety (50%)
4. Accountability and leadership in injury prevention (31%)
5. Evidenced-based planning (31%)

Other principles with at least 15% of the Sydney participants' support included:

- ▶ Evidenced-based planning (24%)
- ▶ Long-term coordinated approach (22%)
- ▶ Community control, empowerment and engagement (22%)
- ▶ Responsive – able to respond to the needs of all populations based on priorities established through evidence (22%)
- ▶ Culturally competent – recognise and respond to unique needs of diverse populations (22%)
- ▶ Sustainability of injury prevention efforts (20%)
- ▶ Monitoring and evaluation of initiatives (16%)

Other principles with at least 15% of the Melbourne participants' support included:

- ▶ Culturally competent – recognise and respond to unique needs of diverse populations (26%)
- ▶ Whole-of-life and person-centred view (21%)
- ▶ Supportive legislation and policy framework (21%)
- ▶ Monitoring and evaluation of initiatives (21%)
- ▶ Innovation (19%)
- ▶ Dynamic – continuously monitor, evaluate, and improve (19%)
- ▶ Community control, empowerment and engagement (17%)
- ▶ Sustainability of injury prevention efforts (17%)

See Appendix B for a list of additional principles supported or suggested.



## Setting Priorities

The groups were asked to consider how priorities would be set within the strategy. These were presented as:

### Injury causes

1. Suicide and self-inflicted injuries
2. Road traffic injuries
3. Poisoning
4. Falls
5. Mental health and substance-use disorders related to injury and trauma e.g. PTSD
6. Drowning and submersion injuries
7. Homicide and violence
8. Burns and scalds
9. Sports and recreations injuries
10. Work place and farm injuries
11. Adverse events

### OR across the life-course

1. Children (0-14 years)
2. Young people (15-24 years)
3. Adults (25-64 years)
4. Older people (65+ years)

### OR by inequity

1. Aboriginal and Torres Strait Islander people
2. Socio-economic groups
3. Rural and remote

### OR by principles

1. Inter-sectoral collaboration
2. Data quality, sharing and timeliness
3. Developing and maintaining an evidence base
4. Sustainability

Themes in terms of general comments noted during this session (excluding those that were covered during other tasks) were:

- ▶ An holistic approach, while difficult, should be a priority
- ▶ Strong reflection of the social determinants of health
- ▶ Consistency of targets is required and acknowledgement of what is already being done
- ▶ Consider a matrix to address the interplays between causes, life stages and inequities.
- ▶ Some noted that there should not be too many priorities while others felt it doesn't make sense to choose particular groups over others, so risk factors should be selected as priorities.
- ▶ Need to focus on high burden and areas in which we know we can make a difference (best buys).
- ▶ Actions need to be realistic and sustainable.

## 1. Injury causes

Discussion on this concept of priorities included:

- ▶ Consideration needs to be given to funding areas not currently well funded, community acceptance of strategies, and sustaining successful interventions and not losing momentum just because they are successful.
- ▶ Broad priorities such as the built environment. For example the role of environment (city design, parks, buildings, roads) on injury and how risk can be minimised and safety enhanced.
- ▶ Need to look at causes rather than the outcomes.
- ▶ We need to bring people in who really understand injury prevention and can help with data - police, health workers, on-the-ground workers etc.
- ▶ Priorities should be data driven.
- ▶ Priority actions should be based on known effectiveness and cost-effectiveness.
- ▶ Innovation as well as addressing new issues (e.g. with changing technology) should be part of the priorities.
- ▶ Risk factors and developmental factors should be key priorities alongside a life-course approach and addressing inequities.
- ▶ Add climate-related injuries to the priorities identified by the literature review.
- ▶ Focus should be on serious injuries and deaths, rather than all hospitalisations.

- ▶ Mental health and, separately, substance-use disorders should be priorities and alcohol and self-harm should be additional and separate priorities.
- ▶ There was a discussion about where consumer product safety might sit.
- ▶ Product safety should be considered.
- ▶ Secondary prevention (to reduce the impact of an injury that has already happened, such as first aid care for a burn injury) should not be overlooked.

## 2. Across the life-course

- ▶ One group thought it was best to focus on life course, but with finer age group divisions.
- ▶ A strong feeling that the life course approach should be integrated with injury risk, for example recognising the impacts of adverse childhood experiences or the intergenerational transfer of disadvantage and its impact on injury risk.
- ▶ Suggestions for holistic planning rather than specific priorities, this includes a focus on: community wellbeing; increasing an understanding of the importance of developing competency in and maintaining physical activity for children and adolescents; creation of safer built environments.
- ▶ Some noted it was time to bring the focus from older people to children and youth – others supported not losing focus on older people.
- ▶ Agreement with the life course approach but with an equity lens.

## 3. By inequity

- ▶ Equity is important and approaches need to be culturally appropriate.
- ▶ Significance and impact should be factored into this, existing evidence should not be a barrier as evidence is currently poor and will always be if addressing inequities is not made a priority.
- ▶ Include gender and people who identify as LGBTIQ.
- ▶ Broader environmental and societal issues experienced by minority groups, e.g. Aboriginal and Torres Strait Islander people should be a focus.

## 4. By principles

- ▶ These principles (listed above) should be objectives of the strategy - mirrored in list of activities/indicators to measure success, i.e. built into an evaluation framework.

- ▶ Strategy development should be guided by three overarching principles: an equity lens for all areas of injury, breaking the Strategy into 'life-course' categories and ensuring that it is written in plain language.
- ▶ Strategy should highlight inter-sectoral collaboration, data quality, data sharing and timeliness and developing and maintaining an evidence base.

## Capturing multiple areas

- ▶ Strategy needs to reflect the interplay between causes of injury and priority populations.
- ▶ Build framework across key risk factors, life-course and inequity – rather than choose between them.

## Other issues raised (and combined with SLIDO open-ended comments)

- ▶ Need to focus on community wellbeing.
- ▶ Need to raise broad awareness of the National Injury Prevention Strategy, so it can be widely actioned.
- ▶ Consider process-based target, milestones and continual review.
- ▶ Considerable support for life-course approach combined with risk factor approach.
- ▶ Promotion of safer health promoting lifestyles – e.g. planning built environments to include safe, active transport.
- ▶ Should be data driven (prevalence, burden) alongside things known to be modifiable, evidence-based.
- ▶ Emphasis on climate change and social determinants of injury.

## SLIDO findings

Participants were then asked to select their top five priorities. Participants were also able to write in their own priorities. These results then determined the topic area for each table to discuss during the afternoon session.

Top five priorities in the Sydney workshop were:

1. Suicide and self-inflicted injuries (40%)
2. Children (0-14 years) (37%)
3. Young people (15-24 years) (37%)
4. Principles: Data quality, sharing and timeliness (37%)
5. Aboriginal and Torres Strait Islander people (33%)

Top five priorities Melbourne workshop were:

1. Falls (40%)
2. Children (0-14 years) (38%)
3. Principles: Inter-sectoral collaboration (38%)
4. Low socio-economic groups (33%)
5. Young people (15-24 years) (31%)

Other priorities - Sydney workshop (supported by at least 20%):

- ▶ Mental health and substance-use disorders (30%)
- ▶ Older people (65+ years) (30%)
- ▶ Falls (28%)
- ▶ Road traffic injuries (26%)
- ▶ Principles: Intersectoral collaboration (26%)
- ▶ Principles: Developing an evidence base (23%)
- ▶ Low socio-economic groups (21%)

Other priorities - Melbourne workshop (supported by at least 20%):

- ▶ Principles: Data quality, sharing and timeliness (31%)
- ▶ Road traffic injuries (29%)
- ▶ Principles: Developing and maintaining an evidence base (29%)
- ▶ Mental health and substance-use disorders (26%)
- ▶ Aboriginal and Torres Strait Islander people (26%)
- ▶ Suicide and self-inflicted injuries (24%)
- ▶ Rural and remote (24%)
- ▶ Adults (25-64 years) (21%)
- ▶ Older people (65+ years) (21%)

See Appendix C for a list of additional priorities supported or suggested.

## 10 Year Actions

Following the ranking of priorities, the group was separated into key topics for further discussion. The key themes covered by these groups (combining those from the two workshops) are as follows:

By inequity:

- ▶ Aboriginal and Torres Strait Islander people and people from low socio-economic groups
- ▶ People living in rural and remote areas

Across the life-course:

- ▶ Children
- ▶ Young people

Injury causes:

- ▶ Falls
- ▶ Mental health and substance abuse (alcohol)
- ▶ Road traffic injury
- ▶ Suicide and self-harm

By principles:

- ▶ Healthy and safe environments
- ▶ Inter-sectoral collaboration and government commitment to inter-sectoral collaboration
- ▶ Social determinants of health

Participants self-selected into topic groups (below) to discuss the following questions:

1. What will be the major enablers and barriers to progressing injury prevention in your topic?
2. Who are the major potential partners for action?
3. What are the most promising interventions?
4. What are feasible desired outcomes?

## Populations that experience inequity

*Aboriginal and Torres Strait Islander people and people from low socio-economic groups*

1. What will be the major enablers and barriers to progressing injury prevention in your topic over the next 10 years?

Enablers:

- ▶ Well-resourced Aboriginal organisations;
- ▶ Well publicised prevention campaigns;
- ▶ Programs that also provide capacity building and employment;
- ▶ The annual Closing the Gap report;
- ▶ Transition to community controlled health organisations, and communities being involved in co-design and management of programs;
- ▶ Accountability measures (including health measures) linked with funding and performance management;

Barriers:

- ▶ Data Issues - identification of data for Aboriginal and Torres Strait Islander people and data not linked between different services;
- ▶ Lack of resources and sustainable funding to support programs long-term;
- ▶ Under-recognition of the role of social determinants of health and the need for cross-sectorial work to address the issue;
- ▶ Remoteness;
- ▶ Under-reporting linked with distrust of services that have historically misrepresented and mistreated;
- ▶ Lack of coordination and communication between sectors/service;
- ▶ Lack of community awareness of the scope and burden;
- ▶ Lack of targeted intervention.

2. Who are the major potential partners for action?

- ▶ Aboriginal Community Controlled organisations;
- ▶ NGOs;
- ▶ Government across all levels and all sectors;
- ▶ Research organisations;
- ▶ Partners that the community respect and trust.

3. What are the most promising interventions?

- ▶ Community led, culturally responsive and strengths based programs;
- ▶ Violence prevention programs;
- ▶ Suicide prevention;
- ▶ Systemic approaches to addressing racism and social justice;
- ▶ Addressing social and cultural determinants;
- ▶ Education and literacy – educational resources;
- ▶ Community and housing safety;
- ▶ Alcohol related interventions;
- ▶ Child home safety including home visiting;
- ▶ Road safety initiatives – child car seat restraint;
- ▶ Early intervention parenting programs that are targeted to low socio-economic groups.

4. What are feasible desired outcomes?

- ▶ Decrease fatal and serious injuries;
- ▶ Decrease in repeat alcohol injuries;
- ▶ Increased engagement by Aboriginal communities and government and NGOs in injury prevention;
- ▶ Metrics and data collection at a post code level to get a better idea of needs;
- ▶ Systematically addressing the social and cultural determinants of health;
- ▶ More resourcing of family services;
- ▶ Investment in education, pre-school and school programs.
- ▶ Programs integrated with other agencies, e.g. housing and education;
- ▶ Taking a holistic approach;
- ▶ A focus on secondary as well as tertiary prevention;
- ▶ Information sharing;
- ▶ Community representation/cultural appropriateness, acknowledging the power of grassroots level engagement early on and with support of governing/representative bodies.

Other points:

- ▶ This should be an area with the most focus and yet it is not very “sexy” or “sellable” in the same way that childhood injury is.
- ▶ Representation for these groups in government is also low and reflects the investment made in this area.



## *Rural communities*

### 1. What will be the major enablers and barriers to progressing injury prevention in your topic over the next 10 years?

#### Enablers:

- ▶ Rural-proofing policy – ensuring policy developed in the city will work in a rural setting;
- ▶ Better infrastructure;
- ▶ Investment – cost-benefit analysis could show that while the expense up-front might be more substantial, it would be worth it in the long run and provide significant injury prevention outcomes;
- ▶ Minimum standards for the workplace and equity in such standards;
- ▶ Recognition of the importance of rural communities;
- ▶ A regional policy, not just a health policy;
- ▶ Investment in research translation – from city based research to a rural setting;
- ▶ Media;
- ▶ Decentralization of city based companies into rural areas;
- ▶ Technology solutions, such as telehealth.

#### Barriers:

- ▶ Rural issues are not a priority even though it is always over-represented in epidemiology;
- ▶ Resourcing and cost – everything costs more to roll out in rural areas and this expense is a barrier;
- ▶ Lack of basic services – phone, internet, power, water;
- ▶ Decision making comes out of the city and is often less relevant or not feasible for the rural settings. Strategies developed in the city just won't work in rural areas because the resources needed aren't available;
- ▶ Distance- for example:
  - (i) with time delays for first responders.
  - (ii) It isn't possible to bicycle or walk to work as a health intervention.
- ▶ Media -lack of coverage on rural issues, but can also be an enabler if they were to cover more rural issues;
- ▶ Unique risks for rural populations that aren't typically considered due to policy being led out of the city. Examples include extreme weather events such as flooding;

- ▶ Digital inequality in rural populations with an over-represented aging population and lack of exposure to technology;
  - ▶ Compounding risk factors – many individuals in rural communities display risk factor on risk factor on risk factor (e.g., mental health issues, people from low socioeconomic groups, alcohol and substance abuse) making it difficult to know what to target first for injury prevention.
2. Who are the major potential partners for action?
- ▶ Intergovernmental and cross sectoral;
  - ▶ All levels of government, local industry and business, regulators (particularly for working conditions), farmers' federation, community groups, country women's association, royal flying doctors, primary health networks.
3. What are the most promising interventions?
- ▶ Using a community based approach looking at community well-being as a whole as this can effect a whole host of other injury related issues. Community participation and consultation is therefore key;
  - ▶ Cardio pulmonary resuscitation and first aid training for everyone (either in high-school in year 10 or with obtaining a driving licence) will mitigate some of the rural faced issues like long delays for first responders;
  - ▶ Digital technology (telehealth) to address resource and distance barriers;
  - ▶ For drowning specifically – a pool with a roof and walls that can be used all year round to help swimming training.
4. What are feasible desired outcomes?
- ▶ Better investment in community driven solutions;
  - ▶ A dramatic decrease in road traffic crashes, suicides and many other injury areas;
  - ▶ It was stressed that for each of the suggested priority injury causes, they are all a rural issue and so taking a holistic approach to community health and rural-proofing policy could broadly affect injury prevention efforts across multiple areas;
  - ▶ Guaranteeing basic services – phone, internet, power, water.
  - ▶ Basic standard of safety, particularly for the workers;
  - ▶ Translating what we know already works in city policy to the rural setting;
  - ▶ More incentives for rural health positions such as physicians and community workers.

## Across the life-course

### *Children 0-14 years*

1. What will be the major enablers and barriers to progressing injury prevention in your topic over the next 10 years?

#### Enablers:

- ▶ Ability to access and share data (conversely, also a barrier);
- ▶ Injury database;
- ▶ Resourcing and funding (also a barrier);
- ▶ Media;
- ▶ Existing policy;
- ▶ Partnerships/collaborations with different skill levels and engagement with community and regulatory power.

#### Barriers:

- ▶ Limited resources;
- ▶ Health literacy levels and the ability to deliver and communicate to a diverse range of groups;
- ▶ Invested/conflicts of interest (from industries and businesses with other agendas other than safety);
- ▶ Loopholes in monitoring and regulating systems;
- ▶ Lack of evidence base in this area- mostly on self-harm;
- ▶ Inconsistent messaging;
- ▶ Replication of programs without evaluation;
- ▶ Lack of funding and on-going financial support. Impacts on collaboration;
- ▶ Remoteness/rural;
- ▶ Lack of sustainable planning;
- ▶ Lack of product safety accountability.

2. Who are the major potential partners for action?

- ▶ Community;
- ▶ Hospital, physician and various other clinicians;
- ▶ Insurance sector;
- ▶ Standards committees, industries and regulators;
- ▶ Parent/consumer advocacy groups;
- ▶ Kidsafe and Youthsafe (NGOs), other government agencies (school/education);
- ▶ Sporting organisations;
- ▶ Commercial partners;
- ▶ Researchers;
- ▶ All levels of government, including planning;
- ▶ Home design and housing organisations.

3. What are the most promising interventions?

- ▶ Community engagement and tailored, multi-faceted interventions;
- ▶ Awareness raising and community education across the life span;
- ▶ Home safety interventions;
- ▶ Effective engagement with parents, carers and other groups (such as grandparents, CALD communities, and foster families);
- ▶ Teaching children to take risks safely;
- ▶ Systemic, regulatory control of products;
- ▶ Cost effective, evidence based (best available);
- ▶ Multifactorial initiatives;
- ▶ Long term culture change/behaviour change;
- ▶ The role of consumers (young people) in co-designing interventions;
- ▶ Consistent messaging across different services;
- ▶ Collaborative partnerships (strength based).

4. What are feasible desired outcomes?

- ▶ Towards zero - fewer hospitalisations and deaths;
- ▶ Health improvement;
- ▶ Injury reduction all causes (less risky behaviours);
- ▶ Consistent messaging across potential partners was a desirable outcome;
- ▶ Reflect on investment capacity when considering desirable outcome.

### *Young people 16-24 years*

Top issues: Motor vehicle, self-harm, sporting, alcohol and other drugs.

Programs should look to other injury and health areas that have had success-cross-referencing in what has worked.

#### 1. What will be the major enablers and barriers to progressing injury prevention in your topic over the next 10 years?

##### Enablers:

- ▶ Connection with other frameworks;
- ▶ Need to identify intersecting with other strategies;
- ▶ Young people at the table;
- ▶ Resourcing for local mental health services;
- ▶ Effective media strategy;
- ▶ Age appropriate engagement and technologies – strong equaliser.

##### Barriers:

- ▶ Lacking resources;
- ▶ Fragmentation of services;
- ▶ Lack of evidence base in this area - mostly on self-harm;
- ▶ Lack of physical activity, lack of preparation for sport for kids, high expectation to perform on kids, when not properly prepared;
- ▶ Issues to address are spread across a range of products and behaviours.
- ▶ Lack of innovation;
- ▶ Lack of urgency - Community attitudes.

#### 2. Who are the major potential partners for action?

- ▶ Young people;
- ▶ Peak bodies for young people such as Youthsafe;
- ▶ Government – health, education, employment, Justice, human services, transport, local;
- ▶ Schools, TAFES and Universities;
- ▶ Workplace (workplace training, driving instruction);
- ▶ Sporting organisations;
- ▶ Commercial partners – such as the video gaming industry who may be partnered with to develop relevant injury prevention IT messaging and applications.

### 3. What are the most promising interventions?

- ▶ Suicide and self-harm – opportunity to leverage off and combine with existing strategies such as:
  - Motor vehicle passenger – enforcement & education campaigns;
  - Occupational injury – multi-faceted approach;
  - Violence – alcohol restrictions;
  - Social determinants – social networks & connections, engagement in education, meaningful employment – driving work participation.

3a. Much of the group discussion focused on factors to consider rather than promising interventions. These factors included the need to:

- ▶ Identify risk factors (supportive networks, out of home young people);
- ▶ Prioritise targeting vulnerable cohorts to ensure proportionate resources are allocated to highest proportionate burden e.g. Aboriginal and Torres Strait Islander young people and young people in rural and remote communities;
- ▶ Incorporate a strengths-based approach in interventions;
- ▶ Build the economic argument (e.g. to consider long-term benefits such as employment, independence, community engagement);
- ▶ Have long-term aims including programs that target long-term culture and behaviour change;
- ▶ Consider equity in developing programs such as programs that rely on having Wi-Fi access;
- ▶ Consider the potential of partnering with commercial companies to encourage health;
- ▶ Utilise technology and youth culture to promote healthy behaviours;
- ▶ Better understand poisoning and accidental overdose to priorities appropriate and promising harm minimisation approaches;
- ▶ Recognise that young people take risks and their perceptions of risk changes based on specific behaviours and influences;
- ▶ Consider the role of consumers (young people) in co-designing interventions.

4. What are feasible desired outcomes?

- ▶ Every death is serious and unacceptable;
- ▶ Overall reduction in injury;
- ▶ Reduction in suicide (halve the rate of suicide; zero);
- ▶ Increased mental health literacy;
- ▶ Strengthen and build safety literacy;
- ▶ Changed trajectory for at risk young people;
- ▶ Increased access to coordinated mental health services – this cohort is the future.

## Injury causes

### *Falls*

1. What will be the major enablers and barriers to progressing injury prevention in your topic over the next 10 years?

#### Enablers:

- ▶ Increased health literacy within the community;
- ▶ Older people: positive messages, e.g. staying healthy, and staying active, increase social participation;
- ▶ Falls in construction: consultation and education;
- ▶ Involvement of community / social settings;
- ▶ Early exposure- reducing stigma, identifying fall risk factors, preventive strategies;
- ▶ Emphasise fall prevention in multiple guidelines, planning and policies;
- ▶ Person centred approach (location, group v individual, program type);
- ▶ Embed fall prevention in health settings;
- ▶ Broad population targeted;
- ▶ Reduce silos.

#### Enablers of falls programs:

- ▶ Increasingly ageing population;
- ▶ High incidence of falls;
- ▶ High cost of falls (especially in work place and in older people);
- ▶ Community aged care packages;
- ▶ Technology to monitor falls risk in the home;
- ▶ Aged care funding instrument;
- ▶ Education of primary healthcare providers.

#### Barriers:

- ▶ Not a 'sexy' topic;
- ▶ Language and stigma, around falls;
- ▶ Need for education of all stakeholders;
- ▶ Inconsistent enforcement of regulation in the area of WorkSafe regulations, particularly for small privately owned businesses;
- ▶ Gap in education related to appropriate exercise programs for older people;



- ▶ Disconnect between hospital and community services;
- ▶ Consumer awareness of risk factors, access to appropriate programs;
- ▶ Lack of knowledge (community and services).

## 2. Who are the major potential partners for action?

- ▶ Retirement centres;
- ▶ Individuals and families;
- ▶ Hospitals;
- ▶ Technology companies;
- ▶ WorkSafe, Safe Work Australia;
- ▶ Insurance companies;
- ▶ Community organisations (e.g., Men's Sheds, RSL, Probus);
- ▶ Arts groups (dance groups);
- ▶ Primary Care/ Aged care providers;
- ▶ Disease specific organisations and professional associations (MS Australia, PD Australia, Alzheimer's Australia, Osteoporosis Australia, Exercise and Sports Science Association);
- ▶ Schools, playgroups;
- ▶ Local government.

## 3. What are the most promising interventions?

### Workplace falls prevention programs:

- ▶ Safety systems, harnessing systems are effective, need a push in ensuring safety measures are implemented.
- ▶ Designing a mechanism to expand safety regulations into private settings and or family owned businesses.

### Children:

- ▶ Make environments safe (playground, sport) while facilitating movement and health. Consider the need for activity across all aspects of lifestyle.

### Community dwelling older adults:

- ▶ Address osteoporosis to reduce impact of falls in older people;
- ▶ Strengthening and balance exercise programs targeting individuals at an earlier stage e.g., Otago' exercise program, 'life' exercise program (needs consistent application across high risk populations, needs to be accessible);
- ▶ Home modifications e.g., handrails, non-slippery floors;

- ▶ Falls Risk Assessments including risk factors for falls e.g., medication review to be performed on high risk groups prior to the fall – potential for greater role for GPs and allied health;
- ▶ Better communication between GP services, pharmacists, community nurses, allied health services;
- ▶ Health promotion campaigns to better understand risks factors associated with falls and to help remove stigma from falls and to help visualise consequences (targeting specific high risk groups, using appropriate methods e.g., radio and television);
- ▶ Where there is moderate effect, further research to determine if interventions will work better in subgroups.

#### Hospital and residential care:

- ▶ Need to increase evidence base around falls in hospitals and residential care.

#### 4. What are feasible desired outcomes?

##### Implementation:

- ▶ Increased implementation of programmes known to be effective;
- ▶ Improved access to programs that target fall prevention.

##### Outcomes:

- ▶ Reduced incidence of falls - Quantify desired % reduction (will differ in different settings, e.g., residential care, community, hospital, work place);
- ▶ Reduced injurious falls, without reduction in activity;
- ▶ Improvement in outcomes that are important to the person;
- ▶ Workplace falls: reducing serious injury and death.

##### The following areas should be the focus:

- ▶ Age related falls (looking specifically at falls in older people – over 65 years);
- ▶ Occupational and environmental related falls.

##### Data source:

- ▶ Self-reported fall data is not reliable;
- ▶ Reporting systems well established for recording falls in hospitals;
- ▶ Work, Health and Safety claims;
- ▶ Child injury admissions to Emergency Departments.

##### Other issues:

- ▶ Need to consider other outcomes, such as resistance training doesn't reduce falls in community dwelling older people, but may

improve other outcomes, e.g., around frailty, loss of dependence, anxiety;

- ▶ Prevention: need to begin younger, at age 45 not 65?
- ▶ Need evaluation of cost-effectiveness;
- ▶ Monitoring and evaluation – improving evidence around the cost of a fall and the cost - effectiveness of interventions.

### *Mental health and substance abuse (alcohol)*

1. What will be the major enablers and barriers to progressing injury prevention in your topic over the next 10 years?

Enablers:

- ▶ National Mental Health Commission and National Mental Health Strategy;
- ▶ Previous National Alcohol Strategy – recognised potential for upcoming National Alcohol Strategy;
- ▶ Existing programs for mental health/community support – these have received enormous amounts of funding in recent years;
- ▶ Need to leverage off suicide and prevention plan;
- ▶ Need to leverage off and avoid duplication with work done under LHN and PHN regional plans;
- ▶ Good understanding of high level policy with big impact e.g., taxation, restriction of supply;
- ▶ Co-development of programs;
- ▶ Peer support /peer led programs;
- ▶ Clinicians – important to data collection and important voice.

Barriers:

- ▶ National Alcohol Strategy not yet reinstated;
- ▶ Lack of resources and resourcing for programs – such as Diversion programs – where people are provided access to mental health services instead of court for minor drug offences;
- ▶ Moving between sectors e.g., between substance abuse sectors and mental health sectors – no commonality in data or treatment – lack of service to support co-morbid conditions;
- ▶ Lack of political will for the big ticket policy stuff that would make a difference with alcohol;
- ▶ Stigma – mental health literacy;
- ▶ Duplication of efforts;
- ▶ Defunding;
- ▶ Lack of evidence around other drugs;
- ▶ Alcohol industry;
- ▶ Increasing consumption of alcohol in women and older adults;
- ▶ Younger population is episodic and binge drinking culture.

2. Who are the major potential partners for action?

- ▶ Local government;
- ▶ Liquor licensing authorities;
- ▶ Emergency Departments;
- ▶ Justice/Prisons e.g., Diversion program;
- ▶ Schools;
- ▶ Mental Health Commission;
- ▶ Private and semi government organisations e.g., Beyond Blue.

3. What are the most promising interventions? (Evidence review will be available)

- ▶ Big policy interventions i.e. taxation and supply restriction for alcohol;
- ▶ Diversion programs seem really promising but are too new for good evidence base;
- ▶ Random Breath Testing works;
- ▶ Increased access to mental health services;
- ▶ Poor evidence for school based program -education integrated across curriculum at earlier age might be a good idea;
- ▶ Parenting programs;
- ▶ Increased access to mental health services;

- ▶ Reducing alcohol related harm through: changes to licensing laws, mass media campaigns, provision of public transport options and promoting their use.

4. What are feasible desired outcomes?

- ▶ Lower prevalence and severity of use and lower involvement of alcohol in injury;
- ▶ Reduction of per capita alcohol consumption in Australia;
- ▶ For other drugs current lack of knowledge hinders setting desired outcomes – perhaps desired outcome could be acquiring this knowledge;
- ▶ Need commitment to research.

*Suicide and self-harm*

1. What will be the major enablers and barriers to progressing injury prevention in your topic over the next 10 years?

Enablers:

- ▶ Making prevention accessible;
- ▶ Leverage current societal mood to address suicide and self-harm;
- ▶ Integration of Alcohol and Other Drugs, Mental Health, Suicide prevention;
- ▶ Currently topical – This is highlighted through the release of the ‘5<sup>th</sup> Plan for Mental Health and Suicide prevention’;
- ▶ Depth of expertise internationally and in Australia for developing suicide and self-harm prevention plans;
- ▶ Injury prevention and mental health both fall under the Ministry of Health, making inter-sectoral collaboration smoother;
- ▶ High level of mental health literacy in the community. This has been identified through Australian psychological evaluations;
- ▶ Mental health Australia – national ethnicity alliance brings in stakeholders from across Australia to design a strategy, therefore culturally appropriate strategies exist for populations from a variety of cultural and ethnic backgrounds;
- ▶ There is a strong ‘Aboriginal and Torres Strait Islander Suicide and Evaluation project (ATSIPEP)’– National program;
- ▶ The government is moving towards regional planning for Mental Health.

Barriers:

- ▶ Data gaps (data quality and access) – no real time suicide data in Australia, working with data that is 2 or more years old;
- ▶ Misclassification of events and diseases leads to likely underestimation of burden of suicide and self-harm. This includes the difficulty in determining intentional versus unintentional injury e.g. self-harm, overdose vs accidental poisoning;
- ▶ Structural issues due to the different sectors involved e.g., commonwealth, state, local government, private and not for profit;
- ▶ Suicide and self-harm is a multi-factorial issue, therefore requires a lot of sectors to collaborate;
- ▶ Suicide and self-harm literacy is relatively low in healthcare workers, many undergraduate nursing programs do not have mental health subjects and/or placements. Teachers have stronger literacy in the area of suicide risk assessments;
- ▶ Health system responses in a timely, integrated, co-ordinated way;
- ▶ Territorialism leading to fractured, disjointed care and services;
- ▶ Understanding difference between impulsive and chronic;
- ▶ Seen as mental health issue – broader than health issues;

2. Who are the major potential partners for action?

- ▶ AOD sector (Alcohol and Other Drugs) – alcohol leading co-morbid factor for suicide;
- ▶ Health – PHN, LHD, Ambulance, Hospital, Police, mental health;
- ▶ National Mental Health Commission and State Mental Health Commissions;
- ▶ AIHW – sentinel data – to have better sharing of data and standardised coding system;
- ▶ Regulators- e.g., the Therapeutic Goods Administration and other pharmaceutical organisations – they could have an important role in the regulation of prescribing dangerous drugs that are commonly used for overdosing;
- ▶ Health, peak bodies and their NGOs – beyondblue;
- ▶ Community – sport, church.

3. What are the most promising interventions? (Evidence review will be available)

- ▶ Means restrictions – broader overlap e.g., physical barriers – this reaches out to community safety as well as suicide and self-harm, and or prescribing, packaging, less toxic pesticides, prescription monitoring program;

- ▶ 'Track safe' – bring together a number of stakeholders around preventing railway injuries. – Safety and suicide – start as a place of safety things like suicide and self-harm can be reduced through the creation of safer environments;
- ▶ Workplace safety – 'Mates in the Workplace' - program about speaking out about mental health – it's common for industrial workplaces that have an emphasis on physical safety to better understand and implement mental health programs;
- ▶ After-care programs are effective but need to be properly managed and supported - people who have made 1<sup>st</sup> attempt of suicide are at risk of having another attempt – people are often not getting connected to services and people have had bad experiences in healthcare services – practice guidelines e.g., following up 24 hours after 1st presentation often not done and not monitored – why are these not being enforced? This is a problem across the board e.g., Hospitals, Family and Community Services, and schools;
- ▶ Increase in safe houses has proven to be effective – moving away from medical model of mental health treatment;
- ▶ 'Step care model' e.g., an intermediate stage between hospital and community care services. This is important because if a mental health client is discharged from an acute service and their condition deteriorates it is easy for them to move back in the acute care service;
- ▶ A wellbeing and collaborative approach should be emphasised – 'moving towards a chose life approach' to make this area more positive;
- ▶ System approaches;
- ▶ Restricting means/ Visibility for interruption;
- ▶ Gate keeper training;
- ▶ Question/ Persuade/ Refer – Peer support;
- ▶ Education – including workforces/public;
- ▶ Responsible reporting;
- ▶ Decrease isolation – improve community connection;
- ▶ Limit alcohol/drug use;
- ▶ Screening by GPs.

Quick wins:

- ▶ Means restriction- need to modality (poisoning, jumping);
- ▶ Community skills training and education;
- ▶ Community driven and owned approaches.

#### 4. What are feasible desired outcomes?

- ▶ Decrease rates of suicide and self-harm;
- ▶ Improve current mental health services, with an emphasis on moving towards a wellbeing approach;
- ▶ Service integration;
- ▶ Reduce rate of suicide and self-harm;
- ▶ Greater awareness and ability to respond effectively;
- ▶ Better data, data sharing, and scientific understanding of the issue;
- ▶ Improved understanding of risk and risk cohorts;
- ▶ Better understanding of health economics of suicide;
- ▶ Integrated/whole of government responses;
- ▶ Community ownership.

#### *Road traffic injury*

The tables noted priorities were to minimise road traffic injury through:

- Utilising existing evidence;
- Promoting active transport in all population groups;
- Adapting the approach to the demography: metro vs rural.

#### 1. What will be the major enablers and barriers to progressing injury prevention in your topic over the next 10 years?

Enablers:

- ▶ Previous successes (e.g., drink-driving countermeasures);
- ▶ Technology solutions. E.g., drink-driving – ignition interlocks and restricting mobile phone use;
- ▶ Autonomous vehicles expected to make significant impact (see qualifying point in “Barriers” dot points below).

Barriers:

- ▶ Cost: Government / taxpayers; or users; Industry: E.g., improved safety usually = increased cost;
- ▶ Political barriers and vested interests. E.g., Political capital burn when attempting modal shift (e.g., Sydney CBD cycling), conflicting priorities including road haulage industry;
- ▶ Increasing traffic congestion;
- ▶ Implications of autonomous vehicles are unclear and may not be entirely positive;



- ▶ Consider security of technology and potential misuse of a centralised system;
- ▶ Lack of readily available data on the societal cost of road transport. E.g., environment, physical activity forgone, loss of community interaction etc.

2. Who are the major potential partners for action?

- ▶ All levels of Government (mainly states) including local councils (urban planning);
- ▶ Major employers;
- ▶ Insurers;
- ▶ Older adult groups;
- ▶ Pedestrian Council Australia;
- ▶ Bicycle Network;
- ▶ Motorist Groups- e.g., National Roads and Motorists' Association (NRMA), Royal Automobile Club of Victoria (RACV), Royal Automobile Club of Queensland (RACQ).

3. What are the most promising interventions?

- ▶ Utilise existing evidence; pick the low-hanging fruit;
- ▶ Promote active transport in all population groups;
- ▶ Adapt the approach to the demography: metro vs rural;
- ▶ Legislation and limiting speeds;
- ▶ Affordable public transport;
- ▶ Engineering and infrastructure, e.g., rumble strips, separated infrastructure for walking and cycling;
- ▶ Newer transport modalities (e.g., e-bikes and e-scooters);
- ▶ Autonomous vehicles;
- ▶ Advanced technology (e.g., vehicle cameras, adaptive cruise control, lane keep assist);
- ▶ Alcohol interlock devices.

4. What are feasible desired outcomes?

- ▶ Reduction in vulnerable road user fatality and serious injury rates (per unit of exposure). The interplay with promoting active modes of transport;
- ▶ Integration, collaborations and learnings between states;
- ▶ Ensuring harmonisation with existing road safety strategies (e.g., National Road Safety Strategy).

5. Other points:

- ▶ Balance between promoting active modes of transport and injuries;
- ▶ Need to acknowledge that we will have an increase in road traffic injury if we continue to promote active modes of transport without supporting necessary infrastructure; challenges with promoting active modes of transport. e.g., cycling is considered unsafe; older adults have struggles using public transport;
- ▶ Adopt best practice and learn between jurisdictions;
- ▶ National harmonisation for driver licensing schemes, particularly with respect to older drivers;
- ▶ Can we incentivise states to improve road safety?
- ▶ Need to disaggregate space;
- ▶ Can we prioritise roads with respect to motor vehicle vs non-motor vehicle transport, encouraging the former and discouraging the latter?
- ▶ Can we introduce incentives to reduce the age of the vehicle fleet?
- ▶ Research question: How to conceptualise and change behaviour in the road environment where there are not obvious agent or environmental interventions (e.g., pedestrians on devices or pedestrians in unsafe environments)?
- ▶ Considerations for underlying societal issues in road user behaviour e.g. Prescription or illicit drug use; distraction; time-poor lifestyles leading to speeding; work pressures leading to fatigue.

## Guiding principles

### *Healthy and safe environments*

1. What will be the major enablers and barriers to progressing injury prevention in your topic over the next 10 years?

#### Enablers:

- ▶ United Nations Sustainable Development Goals approach is about sustainability;
- ▶ Safe, affordable, accessible and sustainable - work, play, live;
- ▶ Advocating safety/ injury prevention into range of policies, plans and strategies. E.g., urban villages – recognising the role environmental design has in injury prevention, safety promotion and healthy living. This highlights the need to consider flooding hazards, walkability, creating a balance between risk and safety/ drowning hazard;
- ▶ Good legislation.

#### Barriers:

- ▶ Too holistic, what are the incentives for other stakeholders?
  - ▶ Don't have the right expertise in the room e.g., things like climate related might be harder;
  - ▶ Long lead-time to see effect.
2. Who are the major potential partners for action?
    - ▶ Big players would be local governments, influence environments, civil societies, clinical advocates, industry.
  3. What are the most promising interventions? (Evidence review will be available)
    - ▶ Healthy cities model, legislative changes for proximal environment impact.
  4. What are feasible desired outcomes?
    - ▶ Indicators for injury – lesser morbidity & disability;
    - ▶ Health – reduction in non-communicable disease, lower on pain, Health-related quality of life, better mental health, reducing inequities using measures like HEAT (Health Equity Assessment Toolkit).

*Inter-sectoral and policy factors*

1. What will be the major enablers and barriers to progressing injury prevention in your topic over the next 5 years?

Enablers:

- ▶ Government need a vision and target;
- ▶ Bipartisan endorsement;
- ▶ Community support/acceptance;
- ▶ Demonstrated wins;
- ▶ Strength based approaches.

Barriers:

- ▶ Evidence base – need Medical Research Future Fund prevention round for research?
- ▶ Funding;
- ▶ Limited resources leads to competitive behaviour between groups.

2. Who are the major potential partners for action?

- ▶ Government agencies;
- ▶ Industry;
- ▶ Community stakeholders;
- ▶ Partnership between federal, state and local.

3. What are the most promising interventions?

- ▶ Policy around data access e.g., linked data, maximising use of data collection and data sharing;
- ▶ Mix of vertical interventions and horizontal – e.g., specific (child car seat) and holistic (early intervention parenting programs);
- ▶ E.g., child car seat programs (early childhood educators, midwives, transport etc.);
- ▶ Injury in all policies;
- ▶ Many successful policy interventions on consumer product, road safety, hot water mixers, pool fences, Australian standards, safety glass etc.

5. What are feasible desired outcomes?

- ▶ Less injury;
- ▶ Having a national coordinating body or committee that brings the different agencies together;
- ▶ National Health Ministers Injury Advisory Council? Reports to Minister. Represents other government agencies, community and stakeholders;
- ▶ Need more compelling way to present data (less flat);
- ▶ Provide mechanism for policy coordination, harmonisation and implementation;
- ▶ Clearing house for injury relevant strategies? Making sure new strategy not at odds with other strategies relevant to injury.

*Social determinants of health*

1. What will be the major enablers and barriers to progressing injury prevention in your topic over the next 5 years?

Enablers:

- ▶ Improved and in-depth data collection and management, and intersectoral analysis;
- ▶ Funding allocations;
- ▶ Geographic mapping.

Barriers:

- ▶ Lack of cross-sectoral communication;
- ▶ Lack of access to medical records and case notes.

2. Who are the major potential partners for action?

- ▶ Local Government Areas, PHNs;
- ▶ Community-based health workers;
- ▶ Volunteer workers;
- ▶ Data collection agencies;
- ▶ Researchers.

3. What are the most promising interventions?

- ▶ Social determinants include: housing, education health and more. Many interventions exist but are broad and the responsibility of separate sectors e.g. Department of Health, Employment, Education etc so it's not really appropriate to develop actions for social determinants in the injury Strategy. Rather we need to consider social determinants as we develop the Strategy. In terms of injury, we may be able to identify feasible interventions and

gaps in the evidence related to social determinants for potential interventions;

- ▶ Mapping injury statistics geographically, disseminate data to Local Government Areas' (LGA) Primary Health Networks (PHNs) and relevant government departments to inform targeted interventions e.g. lots of poisoning in a given area;
- ▶ Data linkage between domestic and workplace violence and injury statistics and case (for example in hospitals, police records, PHN's) to show causal link to identify potential areas of funding.

#### 4. What are feasible desired outcomes?

- ▶ Improved safety in the home;
- ▶ Decrease in childhood injury;
- ▶ Providing an evidence base to inform LGA/PHN's about prevalent injuries in their areas;
- ▶ A better understanding and awareness that violence in the home and the workplace will result in injury.

#### 5. Other points:

- ▶ Community nurses providing post-natal visits could distribute brochures on free safety consultations in the home to identify safety risks for children. Allocated spend for low income health care card holders for safety equipment and others able to purchase with free installation.
- ▶ Increased funding, staff and volunteer training and incentives to support the Translating and Interpreting Service and Aboriginal and Torres Strait Islander volunteers who work with hospitals so that the service is freely available (no long phone calls on hold) and the staff have an understanding of injury etc. that they are dealing with/asking about.
- ▶ Important to identify causes of injury and effective strategies in for people and communities from low socio-economic groups;
- ▶ Detailed sentinel hospitals data collection (pilot);
- ▶ Proposed Intervention: distribute child-safe containers for illicit drugs;
- ▶ Interventions need to be culturally sensitive and understanding.
- ▶ 'Safety pathway' - need to address violence against women in diverse cultural groups;
- ▶ Rural/remoteness –. Need education programs about violent behaviour/unsafe behaviours not being normal in the rest of Australia, where there has been generational abuse;
- ▶ For social determinants, need a staged approach Identifying postcodes and relating to injury statistics, then disseminating

information to LGA's and relevant government departments to decide funding allocations;

- ▶ Focus on non-English speaking people and Aboriginal and Torres Strait Islander people for injury prevention (e.g. poisons, car safety etc.);
- ▶ Intersectional analysis essential – need lived experience, gender in relation to age/socio-economic background/ cultural identity/ (dis)ability, etc.

Comments from the floor regarding this table presentation:

- ▶ Support for 'change the rules' campaign in ACT;
- ▶ Mapping for injury already done by Monash University;
- ▶ Need workers not volunteers for Aboriginal and Torres Strait Islander people. [NOTE: Comment from the floor – there already exists an extremely high level of volunteerism among Aboriginal and Torres Strait Islander people. More in keeping with social determinants of health would be to strengthen roles of Aboriginal Liaison Officers and Health Workers and recognise unique knowledge and skill required in the work.]

Additional notes at the completion of the table presentations

- ▶ Alcohol strategy was good but lacked accountability;
- ▶ Need a matrix to show interplay of injury and population (could be tick box as to injury areas that affect each group);
- ▶ Recognising complexity between increasing activity and increasing injury but overall net benefit;
- ▶ Provide safe environments- rather than focusing on injury/risk-create targets that address this. E.g. 50% of older people doing exercise, 25% of workers cycling/walking/running to work;
- ▶ Strategy should include pages to show how to prioritise, link to national standards. This will help activation to be diverse (for example, community groups can see how their works fits within the strategy);
- ▶ Where can this add value and link in with other strategies that exist?
- ▶ Links to other areas clearly came through, how does injury link e.g., drug and alcohol;
- ▶ Interconnectedness of injury to other health areas;
- ▶ Embrace systems thinking;
- ▶ Gaps, sleep and medication, chronic pain, osteoporosis, climate change, grey literature and evidence other than academic literature;

- ▶ Haven't seen improvement, probably need to have a more granular approach to design of interventions, need to think about primary secondary and tertiary intervention;
- ▶ More refined approach in terms of priority setting;
- ▶ Want strategy to be upstream, through improving social and economic structures and processes to decrease barriers and address social determinants of health and injury more broadly;
- ▶ Safe environments and health promotion thinking not just health protection thinking;
- ▶ Local populations and particular groups and areas need to be involved and have value in the strategy including Aboriginal and Torres Strait Islander people;
- ▶ Strategy to be clear about what it is and what it isn't;
- ▶ Cross sector approach, flexibility, co-design, academic community saying we need more research but need to drill down into what works and what doesn't, others saying no let's work with what we already know;
- ▶ Add complexity- could include matrix, life course and equity.
- ▶ Visibility of this strategy and promoting as issue to population at large, 10yr strategy is a long time;
- ▶ Role of regulation- why so much variation across jurisdictions?
- ▶ Risk, equity, life course;
- ▶ Good to be having discussion, but lack of resourcing from government.



## Facilitators' remarks

At the conclusion of the Round Table presentations and discussion, the facilitators brought all discussion together by providing their insights and summaries from the day. Summaries of the facilitators' perspectives are combined below:

### 1. Stakeholder perspectives on cross-sector national strategy

Participants recognised that this national strategy will be sitting amongst many other related and relevant strategies such as Closing the Gap, mental health and suicide, alcohol and substance abuse and road traffic injuries. It would be valuable if this strategy could find a way of linking to these, and drawing proposed actions together, through the lens of injury, rather than overlapping and duplicating.

### 2. Test and add to information gathered (AIHW presentation and work in progress of the review of evidence of effective interventions)

In many cases risks related to several outcomes, and, as has been the case with chronic disease there may be value in shifting from a focus primarily on individual outcomes, to a focus on risks and social determinants.

Support for broadening from a health protection/harm minimisation focus to also include health promotion was noted. The example given in drowning, where there is now recognition that focus on the prevention of drownings, to some extent has been a missed opportunity to promote a water safety culture more broadly. Note, not either or, but a broadening out and adding to. A number of specific comments about additional information was made during the floor discussions. These included:

- Osteoporosis and the impact of that on the injury burden associated with falls;
- Attention to supply strategies for alcohol (eg taxation), and others, eg consumer products;
- Sleep and medication and the role this plays in injury (falls);
- Climate change – and the impact of climate change on injury through events such as severe flooding but also through social impact of drought;
- Chronic pain – how that is managed and the legacy of injury;
- Do not want strategy limited to interventions where there is only a strong evidence base, would like to see a flexible Strategy that fosters innovation;
- Alcohol strategy (noting that after consultations this seems to have disappeared or faltered – [this was noted by delegates at both Round Tables])
- Recognise impact rather than just severity, e.g. large numbers of lesser morbidity may have big impact;
- Noted that last decade has not seen improvement at overall levels of injuries – need to have more refined objectives, also need to operate in realms of primary (direct injury prevention), secondary (early measurement

and preventing subsequent injury such as effective first aid) and tertiary (improving quality of life and impacts of previous injury through treatment or rehabilitation) prevention.

### 3. National Injury Prevention Strategy

- Participants had trouble relating to the elements listed during the Sydney Round Table.[Note: As a result, this was captured in the broader discussion in Melbourne regarding principles and priorities of a National Injury Prevention Strategy rather than as a 'stand-alone' topic.]
- As well as comments regarding upstreaming to risks and social determinants, and broadening from health protection to include health promotion, participants considered it would be suitable for the national Injury Strategy to be written in such a way as providing guidance for local priority setting. Other participants wanted the strategy to be clear about accountability, roles and responsibilities.
- The guiding principles discussion went well. The SLIDO ranking was helpful and participants would like to see co-design, implementing what we already know, cross-sectoral, resourcing, and flexibility included as guiding principles for further consideration. There were differing views on more research. Some participants focussed on knowledge gaps, others felt the strategy should focus on implementing what we already know.

### 4. Priorities and actions

- Canadian criteria accepted, in that they were not objected to. [Note: The Canadian criteria for identifying injury prevention priorities is a matrix of injury areas assessed for their: “importance” (burden of injury), “modifiability” (effective interventions), “feasibility” (capacity to deliver the interventions), “acceptance” (community and government interest in and support of the interventions) and “evaluability” (established measures and indicators of success).]<sup>3</sup>
- A matrix approach was considered to have potential – if an injury type is considered, break it down by life course and equity.
- Presentations back to the group during the afternoon sessions showed that groups who were given a target population had more success in generating cross sector, up-streamed ideas.

Delegates were encouraged to bring the voice of community to the strategy. Examples of this were provided through the Victorian Disability Strategy where the voice of end-recipients was a core component of the strategy.

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<sup>3</sup> Oakey M and the BC Injury Research and Prevention Unit. Provincial Injury Prevention Priorities. Report of the BC Injury Prevention Committee. July 2017.

## Next Steps

Kate Hunter concluded each Round Table by thanking the delegates, Round Table facilitators and scribes. Moving forward an Expert Advisory Group would be convened. Interested delegates were encouraged to send through their nomination (contact details and a short biography) to the Injury Strategy email address: [InjuryStrategy@georgeinstitute.org.au](mailto:InjuryStrategy@georgeinstitute.org.au)

Delegates were informed that the Expert Advisory Group would convene via teleconference approximately four to six times over the next twelve months to shape the Strategy. Each progressive iteration of the Strategy as it is developed over the coming months will be further shaped by the ongoing consultative process (meetings across each of the remaining capital cities and Alice Springs, consultation with both government and the public).

Delegates were encouraged to provide any additional comments via the Injury Strategy email.

## Appendix A: Delegates

A total of 291 people representing 71 government (state and federal) departments and 119 non-government departments and organisations were invited to attend the Round Tables. Of those, 115 people from 22 government departments and 58 non-government organisations, universities and research institutes attended. The following is a list of those government departments and non-government organisations and entities represented at the Round Tables:

### *Government departments*

- ▶ ACT Children and Young People Death Review Committee
- ▶ Australian Commission on Safety and Quality in Health Care
- ▶ Australian Competition and Consumer Commission
- ▶ Australian Government Department of Health
- ▶ Australian Institute of Health & Welfare (AIHW)
- ▶ Comcare
- ▶ Commission for Children & Young People
- ▶ Department of Education & Training (Vic)
- ▶ Department of Health
- ▶ Department of Health & Human Services Tas
- ▶ Department of Health & Human Services Vic
- ▶ Department of Social Services
- ▶ National Critical Care Response Centre
- ▶ National Disability Insurance Agency
- ▶ National Mental Health Commission
- ▶ NSW Advocate for Children & Young People
- ▶ NSW Centre for Road Safety
- ▶ NSW Health
- ▶ NSW Poisons Information Centre
- ▶ Queensland Health
- ▶ Safe Work Australia
- ▶ The Children's Hospital at Westmead
- ▶ The Sydney Children's Hospital Network
- ▶ Vic Roads

*Non-government organisations*

- ▶ Allied Health Professions Australia
- ▶ Ambulance Victoria
- ▶ Australasian Injury Prevention Network
- ▶ Australian & New Zealand Burn Association
- ▶ Australian Catholic University
- ▶ Australian College of Nursing
- ▶ Australian Health Services Research Institute (AHSRI), University of Wollongong
- ▶ Australian Longitudinal Study on Women's Health, University of Newcastle
- ▶ Australian Longitudinal Study on Women's Health, University of Queensland
- ▶ Australian Primary Health Care Nurses Association
- ▶ Australian Ski Patrol Association
- ▶ Australian Water Safety Council
- ▶ Brain Injury Australia
- ▶ Centre for Youth Substance Abuse Research
- ▶ Childhood Injury Prevention Alliance
- ▶ Children's Healthcare Australasia
- ▶ CHOICE Australian Consumers Association
- ▶ Federation of Ethnic Communities' Councils of Australia
- ▶ Federation University
- ▶ Griffith University
- ▶ Injury Matters
- ▶ Institute for Governance and Policy Analysis (National Centre for Social and Economic Modelling) University of Canberra
- ▶ Jean Hailes Foundation
- ▶ KIDS Foundation
- ▶ Kidsafe - NSW
- ▶ Kidsafe - Vic
- ▶ Kidsafe - WA
- ▶ Macquarie University
- ▶ Monash University
- ▶ Monash University, Accident Research Centre
- ▶ Monash University, Behaviour Works Australia (research)

- ▶ Monash University, School of Clinical Sciences
- ▶ Multicultural Centre for Women's Health
- ▶ National Injury Surveillance Unit
- ▶ National Rural Health Alliance
- ▶ Pharmacy Guild of Australia
- ▶ Playgroups Australia
- ▶ Primary Health Network
- ▶ Public Health Association of Australia
- ▶ Public Health Association of Australia Injury Prevention Special Interest Group
- ▶ Public Health Information Development Unit
- ▶ Queensland University of Technology
- ▶ Royal Life Saving Society - Australia
- ▶ Safety Institute of Australia
- ▶ Society of Automotive Engineers Australia
- ▶ The Australian Pain Society Ltd
- ▶ The George Institute for Global Health
- ▶ Turning Point, Monash University
- ▶ University of Adelaide
- ▶ University of Melbourne
- ▶ University of New South Wales
- ▶ University of Newcastle
- ▶ University of Sydney
- ▶ University of Sydney, Institute for Musculoskeletal Health
- ▶ Vic Injury Surveillance Unit - Monash University
- ▶ Victorian Institute of Forensic Medicine

## Appendix B: Additional principles identified

The following are delegates' suggestions of additional principles that should guide a National Injury Prevention Strategy. Delegates' input was via SLIDO, an interactive online tool.

Sydney:

- ▶ Accountability at strategic and individual action level, tangibility of actions;
- ▶ Action focused- Technology enhanced;
- ▶ Actual accountability - monitoring and evaluation needs to be followed up and questions must be asked about why 'action indicators' were not achieved. All areas of government must be committed and demonstrate commitment.
- ▶ Adequately resourced such that there is appropriate resourcing for implementation as well as independent monitoring and evaluation;
- ▶ Co-design;
- ▶ Commitment to equity of access for Refugee and Immigrant health population;
- ▶ Cost-benefits/ effectiveness;
- ▶ Costs and community benefits of action;
- ▶ Equity of impact- Cost-benefit analysis;
- ▶ Inclusive;
- ▶ Independence from government;
- ▶ Many of principles can be grouped ;
- ▶ Marketing and communications should be behaviour change informed;
- ▶ Do what we already know and get quick wins –targets - accountability;
- ▶ Monitoring data;
- ▶ Need to include expert opinion where no evidence is available;
- ▶ People with a lived experience, and responsiveness to the unique challenges of vulnerable groups including refugees and migrants;
- ▶ Scalability of programs;
- ▶ Targets for positively framed interventions that make a difference.

Melbourne:

- ▶ Aboriginal and Torres Strait Islander definitions of health incorporating spirituality, culture and healing; Supportive legislation and policy framework;
- ▶ Acknowledging Injury is preventable. Leadership visibility of problem. Exposure;
- ▶ Broad commitment to equity and inclusion;
- ▶ Build capacity;
- ▶ Cross system approach looking at cost benefits of considering co-morbid impacts e.g. disability, mental health, injury;
- ▶ Data sharing across the sector (default position);
- ▶ Evidence guided, truly innovative ideas won't have evidence- policy focussed interventions that cut across all aspects of injury prevention i.e. Alcohol Pricing, advertising and availability social determinants of Injury approach;
- ▶ Funding;
- ▶ Gender awareness and intersectional approaches;
- ▶ Investment in blue sky approach should continue;
- ▶ Leadership (which goes beyond coordination).
- ▶ Visibility (injury must be made visible in order to be the subject of effective action);
- ▶ Learn by doing;
- ▶ Long term cross sectoral collaboration and commitment (public, private, non-profit and community). Resourcing is a given if there is high level of commitment and accountability.
- ▶ Preventability; visibility; exposure; leadership; equity - better expressed than as above, incl. Aboriginal, non-Indigenous;
- ▶ Priority populations;
- ▶ Visibility of the injury problem: measure and analyse data, analyse and link data, dissemination of information.



## Appendix C: Additional priorities identified

The following are delegates' suggestions of additional priority setting that should guide a National Injury Prevention Strategy. Delegates' input was via SLIDO, an interactive online tool.

Sydney:

- ▶ Approach to risk - how to build skills in managing risk (rather than avoiding risk) Change life course to 5 groups (pre-birth- 5; 5-17; 18-30; 30-65; +65). Make life course the highest level structure with the others as cross factors within each age range.
- ▶ Avoid groups competing against each other - old people versus kids as an example. A united voice to government likely to be more effective.
- ▶ Challenging, Risk stratification, burden of disease, potential years of life lost measures.
- ▶ Culturally and linguistically diverse communities, LGBTIQ.
- ▶ Life course, inequity and principles listed should be embedded within injury causes. Mental health and substance use disorders (and not just those related to injury and trauma) could capture suicide and self-inflicted injuries.
- ▶ Life-course risk factor orientation.
- ▶ List should be risk focused. Not injury. This list would include modifiable behaviour that is effective in targeted interventions and policy.
- ▶ Matrix of priorities that encompasses causes and vulnerabilities in different population groups Consistency of priority across groups, locations to enable shared approach and accountability.
- ▶ Milestones.
- ▶ Monitoring of emerging injury issues.
- ▶ Priorities should be determined based on an analysis of impact, prevalence, costs to government/communities, and where there's greatest opportunity to impact etc. would need further analysis.
- ▶ Promotion of a safe healthy lifestyle.
- ▶ "Substance use" not under Mental Health, and maybe Mental Health and LGBTIQ should be included with "equity". Post-traumatic stress disorder is important and the impact of injuries can impact on others close to them, either family, friends or witnesses.
- ▶ Suggest life courses as initial framework and then injury types - this may assist in identifying gaps. Equity and other principles are then required for every stage. Mentioned 'risk adversity' - not sure where that fits.
- ▶ The priorities should be injuries across the life course. Inequity should be embedded in all of them.
- ▶ The priority areas need to be determined by what the data is telling us, where are our high need areas.

Melbourne:

- ▶ A greater focus on risk factors that increase risk for multiple outcomes (e.g., alcohol abuse).
- ▶ A somewhat eclectic mixture is likely to be best, given the complexity and diversity of the issue. For example, include some themes on the basis of potential for early achievability, even if they do not account for a large part of the total burden, as well as some more challenging, longer-term themes that have potential to deal with a larger part of the total burden. The topics chosen are likely to involve external causes (including some not listed, such as alcohol), life-course as well as Indigenous status/SES/remoteness and other characteristics.
- ▶ Address risk factors that affect whole population not individual risk groups such as alcohol, climate change and social determinants of injury. Cross-cutting across other health/social issues - e.g., alcohol, active transport. Need to reframe our approaches to real multi-sectoral involvement - not just multi-sectoral within injury.
- ▶ Built environment and safe environments. Need to consider timeframe of immediate, medium and long term. Needs to be scope for diversity in approaches.
- ▶ Difficult to prioritise on above themes...needs more nuance and acknowledgement of complexity.
- ▶ Early intervention prevention focussing on comorbid factors and crosscutting issues
- ▶ In an ageing population, grouping all older people aged 65+ as one is too simplistic for example, frail older people and those with dementia would have different needs to fitter, older people.
- ▶ In terms of approaches, intersectionality must be included to understand all communities notably culturally and linguistically diverse communities, migrant women, people with a disability.
- ▶ Need holistic programs that address injuries and other conditions e.g., investment in active transport promotes physical activity across the life course which impacts on falls in older people.
- ▶ Need to analyse a range of interrelated criteria to inform decision e.g., prevalence, burden, modifiable, evidence (combination of refined and pilot interventions).
- ▶ Older people 85+ years.
- ▶ Focus on particular transport injury issues such as bicycle and off-road motorcycle injuries.
- ▶ Polypharmacy and medication misadventure.
- ▶ Risk factors such as alcohol, social inequity i.e. focus on greatest disadvantage and focus on greater burden of disease.
- ▶ Sustainability.