The Strategic directions for injury prevention in Australia workshop, held on 20.9.18 at the Victoria Institute for Forensic Medicine, was presented as a Call to Action for a collaborative, loud and united approach to address the complex nature of injury prevention across Australia.

In response to a government initiative for a National Injury Prevention Strategy to be completed 2019-20, it follows the expiry of the last three-year plan. Further workshop(s) will lead up to a Forum ~ March 2019. The Monitoring and Reporting Framework will be completed in 2020-21.

The workshop was jointly hosted by VIFM, the Monash Department of Forensic Medicine (DFM) and the Australasian Injury Prevention Network. It included speakers from the Commonwealth Department of Health, the Australian Institute of Health and Welfare, Flinders University and the DFM and 51 participants from all Australian States and Territories and New Zealand. Professor Rebecca Ivers (Head of the School of Public Health UNSW and Chair of the AIPN) chaired the workshop.

Alan Philp highlighted the plateau in effectiveness of current road injury prevention strategies and the need to reduce the burden, costing $30 billion a year. Born by the Health budget, there has been no substantial link between injury management and injury prevention.

For details please see workshop presentations by speakers Alan Philp, Prof James Harrison, Karen Bishop, and Prof Joan Ozanne-Smith, chaired by Prof Rebecca Ivers, and informed by the V.I.F.M. Oration guest speaker Prof Adnan Hyder on 19.9.18. Prof Hyder provided his reflections on the workshop proceedings and the opportunities posed by the upcoming development of the new National Injury Prevention Strategy.

The Workshop organisers are grateful to Gillian Schofield for her comprehensive note-taking and compilation and to Rosalie Clementson and Sarah Travers for administration and assistance at the workshop.

The discussion following the presentations is summarized as follows:

**“Must Have” criteria for strategic directions in injury prevention:**

* Targeted call for injury prevention and an implementation plan. Focus on strategy first.
* Best representation from the community; bring together key players.
* A united voice for injury prevention, we need a *National Injury Alliance*. It must be loud.
* Evidence based, measurable, with targets and to be accountable.
* Funding for action on injury prevention from vested interest NGOs, eg. Insurers.
* Consistent input requires cross party commitment.
* Key areas with action items for a manageable strategy to work through incrementally.
* Linkages between plans; across all areas.
* “Injury” is an old term but it is useful and needs to be emphasized for preventative action; needs a new, collective voice to be heard, for a single benefit.
* Leadership around a national outcome, KPIs, actions and accountability; working horizontally across all agencies and organisations, and involving the whole of government.
* A stronger strategy to spread the funding burden beyond the fluctuations of government.

**“Must Do” list**

* Change culture through education, eg As with protecting the environment, put energy into the young growing up believing injury can be prevented.
* Bottom – up approach. Build strong families through strong communities as a foundation for life through the early years. Early Intervention.
* Holistic, inclusive collaborative approach: “Nothing about us without us”. Health literacy and education for behaviour change in Aboriginal and Torres Strait Island communities. Community to work with policy makers, eg regarding drinking alcohol on/around waterways.
* Broad Brush Approach.
* Legislation is the biggest lever for change, eg cigarette packaging
* Big Picture.
* Longevity for funding, eg “Farm Safe” funding to address rural/remote farm injuries was lost 10 years ago.
* Re-frame the injury prevention language used, eg To engage men to look after their health. To convince farmers to adopt safety practices. Rural settings are talking a different language, have a different culture. “We are out of step”.
* Child protection is everyone’s business.
* Injury is everyone’s business.
* Embrace digital technology.
* Influence funding decisions at all levels, by business and by governments around investment in injury prevention. Measure of success will be the ability to specifically influence money spent by others and numbers of state governments joining in, eg Australian Water Safety.
* Engage Insurers in funding injury prevention strategies.
* Strong advocacy for long term block funding for research (US model through Centers for Disease Control).
* Set an action plan.
* Be loud on social media to influence governments about where their priorities are.
* Ask government to tackle the alcohol industry.

**Multiple domains were identified:** including

* Public education – use of frontline accounts to impact public opinion.
* School education – learning that injury can be prevented.
* Preventative materials.
* Product Safety – does not have a lot of attention at present.
* Industry standards & Regulation– Slow pace of change in Australia, eg 7 year waiting time to implement basic internationally-recognised safety standards through Australian legislation.
* Inadequacy of standard data reporting practices in clinical settings, eg only impact data not cause data can be recorded for burns injuries.

**Successful Models for Change,** to apply to the injury prevention domain, were identified**:**

* The recent Endometriosis Research initiative used a combination of literature review, expert group to guide the work, forum, public consultation, creating the right strategies with the right people and the best representation from the community. Plus a bottom-to-top approach: lobbying a government/ministers seen to be responsive to a loud, united public voice.
* Building Environmental awareness in schools.
* Men’s, Women’s and Children’s Health Strategy initiatives.
* European models of change: use of insurance penalties for young drivers to change behaviours and reduce injuries.
* CDC National Centre for Injury Prevention and Control; National Preventative Materials.
* Existing effective preventative measures, eg falls in the elderly. How to scale up these measures with implementation and evaluation?
* BehaviourWorks Australia’s successful 000 Campaign. Behaviour change researchers utilize the human factors that motivate people as opposed to ‘knowledge’ as a deterrent.
* VIFM case studies can inform and change industry/ manufacturing perspectives and decisions, eg Blind Chord strangulation case studies presented at a manufacturers conference led to change in the industry. De-identified case studies had more impact than data.
* St Kilda Mums group removes unsafe baby equipment from the second-hand market before being recycled to vulnerable families. This is a huge area with a lot of unsafe products.
* A linked data system for Sth Aust Early Childhood Development allows us to learn more about families with increasing sophistication from crosscutting areas of responsibility: education, entertainment, police, health outcomes 🡪 How to deal with the tougher issues around this, eg child protection.
* Taxation disincentives have been most effective, eg Alcopop Tax. This generation is the first to drink less alcohol than their parents.
* Australian Sports Brain Bank initiative, Sydney Uni: brain donation set up for future research on concussion in footballers.

**Key Players may include:**

* College of Road Safety - can run workshops; support writing of grants; squeaky wheel; lobby.
* ACRS – Australian Consumer Retail and Services, commercial research unit, Monash Uni.
* Public Safety organisations, eg Australian Water Safety Council.
* KidSafe – Child Accident Prevention Foundation of Australia.
* CHIPA -Childhood Injury Prevention Alliance.
* AMA has a strong voice but not much action.
* AFL, VFL - kids and better training to avoid sports injuries. Rates of injury are still challenging.
* There are a handful of industries who are concerned with product safety, for best practice guidelines, eg relating to children’s accessories & furniture.
* Media and Social Media.
* Government: setting a priority in response to public demand; re-setting government guidelines so they incorporate injury prevention, eg NH&MRC; Action plan; 5 year cycles.
* Insurers. There are benefits for those who pay out to participate in injury prevention funding strategies.
* Australian Insurance Council.
* NH&MRC: Long term block funding for policy research and injury prevention research; funding for more intervention preventative health studies and recognition of their importance.
* National Coronial Information System. An underutilized resource due to ethics delays to access data.
* Australia Bureau of Statistics. Funding is one of the significant issues re special survey data requests in specific areas of interest eg farm safety.
* Old ABS household survey data exists for Vic and NSW (1990s)on products such as firearms, bunkbeds (supplementary surveys to Labour Force Surveys negotiated via Vic and NSW Health Departments). Need critical thinking and/or a strategy on how to put pressure on ABS [for new data collection].
* Need for an umbrella organisation to coordinate and prioritize requests to ABS.
* Clinical groups to work with data and reporting gaps.
* BehaviourWorks Australia regarding strategies to better influence policy makers.
* Strategic alliances with Aboriginal communities with respect for culture; how to empower them to make it work.

**Identified areas of recognised need:**

* Proactively address the potential threats, eg alcohol labelling for pregnancy has been met by push back from the alcohol industry and government ministers.
* The issue of Regulation for Product Safety and Standards. Australia is behind other countries. Product safety does not get a lot of attention in Australia. It is a reactive process, eg quad bikes, teething necklaces, blind cord strangulation.
* Population Health is about joining the dots, eg how better to reduce suicide in the community.
* Public health is showing us what we need to do.
* Fix the NH&MRC guidelines so the process is better for injury prevention research.
* Sports Injury Guidelines and a commitment to enact the guidelines.
* A Concussion App.
* Injury Specific Advocacy eg via injury strategist.
* Advocacy for Injury Prevention for Adolescents.
* Data Registries are not sophisticated enough to capture the required data. eg Data on Burns and trauma through product failure, they record impact not cause of injury. Standard practices are lacking.
* Big Picture: the need to challenge Australian male notions of masculinity, and the Aussi Culture traditional construct ( ‘WASP’ tradition – white anglo-saxon protestant), including amongst a generation of policymakers and members of parliament.
* Need to focus on only a couple of areas with good, known, effective strategies.
* Best practice regarding children’s accessories and furniture – product safety.
* If children are our future, where is the evidence/funding to support this.

**Other Issues raised by speakers/participants:**

* Injury is lost as a voice because other organisations are louder and better resourced, eg diabetes.
* Collaboration across all spheres of Australian life needed to raise the profile of injury prevention.
* Data linkage is great but not enough to form an intervention strategy eg on drowning.
* The 2011 data (and data quoted by the Medical Research Future Fund) is clear about what needs to be tackled. How do we get action/funding?
* The 2004 Injury Prevention Plan was not successful in making linkages to address the complexity of the challenge.
* The need for individual and societal responsibility around injury prevention.
* Reframe the language used, eg on risk and speeding = language of disconnect.
* Gaps in the data that need filling/reframing,

eg assumptions about recovery time not born out by the data: 2-5 years post injury still disabled.

* People talk about working together until competition for the $ divides voices.
* Timelines and delays in the release of data, eg 2016 just released; current use of 2011 data makes it clear what needs to be done.
* Injury prevention currently in the domain of anti-terrorism and safeguarding.
* NH&MRC – little injury prevention research funding occurring here (misclassification inflates actual)
* Injury Prevention has not been talked about as a health priority for some time now.
* Lack of funding for NGOs.
* The hard conversation around the need for change. Some people might have to give up some things. We are going to have to change how we do things.
* We now have a de-regulated industry for Product Safety and Standards; it is hard to regulate; Australia does not have standards for a lot of things. We have a reactive system.
* Implementing a levy on products could be a way of putting money back into regulation, recall, advertisements, education.
* W.A. ‘Cost of injury’ data is good but no cost on prevention.
* GFC led to low research funding and soft options not funded. It takes time to generate data.
* Absence of a Child-Adolescent Strategy at Commonwealth level.
* Children are our future. Need to ensure childhood safety with significant early interventions.
* Cost effectiveness is better than cost-benefit analyses. The latter is a limiting attitude that blocks access to funding and needs challenging.
* There is currently no national authority providing leadership and action on injury prevention.
* Regulatory environments, eg in farm communities, should be work safe but there is a high burden of motorbike injuries on farms with high threat to life and spinal cord injuries.
* Suggestion of a user pays levy to promote the use of the safe products raised equity issues.
* It may be helpful if we are not issue focused. More emphasis needed on capacity building, identifying the focus and the sector getting together to organise themselves.
* That there is no new money for a new group will be a limitation.
* There is not a lot of injury policy expertise in Australia.
* Intentional and unintentional injury.
* We don’t want to be back here again in 10 years having the same conversations.
* If this is a Call to Action, we need to take risks to deal with this.

**Strategies**

* Strategies by age: children, young people, old.
* Strategies by topic: suicide, road traffic, falls, violence.
* Action items across the life course: Children
  + Age 0-4 is too broad with too many inconsistencies. However 70-80% deaths in children involve lack of parental supervision. Action: early intervention, supervision, health literacy for parents, safety, injury prevention, positive parenting.
  + Technology advice can be inappropriate, eg phone apps on children.
  + Hard copy material in a bag from Maternal Health Program may not be effective🡪 bin.
  + Many groups work with this age group, engage with vulnerable groups.
  + An injury prevention mechanism-specific approach will not work because of the complexity of the housing, education and justice issues, eg for vulnerable families.
  + Injury in this area of vulnerable families and peak bodies or community organisations is not high on the agenda/radar, even though it is clearly high on the graphs. It needs a higher profile.
  + Broad brush programs exist in early intervention with literacy, childhood education, pre-natal, foetal alcohol spectrum.
  + All specific programs eg drowning, need to feed into and be embedded in broader brush programs.
* School-based; supervision; environments in deprived neighbourhoods – looking at the language and constructs for injury prevention programs.
* Safe systems approach, safe products, safe environments reduces pressure on supervision.
* Action items across the life course: children, adolescents and young people
  + Assaults, falls, suicide, road traffic, alcohol and drugs, pill testing at festivals.
  + Systems approach – rural and remote.
  + Vocational training.
  + Community led solutions.
  + Taxation on alcopops.
  + No alcohol advertisements at sporting events; ditto gambling ads.
  + Injury specific advocacy; injury strategists.
  + Need to advocate for injury prevention for adolescents in light of current trends in pushing young people into contact sports.
  + Need for a concussion App.

**Reflections to help a formal process** by Prof Adnan Hyder – finale to workshop session

* Why now? Define why this year; incredibly important especially for Governments
* What is your political goal? Don’t hide it. Integration with other sectors
* Make injury prevention the priority
* Broaden and enrich a new perspective via relevant participants; watch it develop over time
* Identify your vulnerable groups: racial, ethnic religious. Mention explicitly and cover them
* Invest in interventions, not diseases. Don’t fight about the burden but about the solutions
* Accountability. Not reports with no impact.

**Six Things to consider** by Prof Adnan Hyder – finale to workshop session

* Mandate
* Technical Strength – Evidence based
* Capacity to implement
* Resources
* Time Frame
* Social Accountability

**The Next Steps**

* Broadening the framework of reference across the community (LISTS compiled for Commonwealth Health at this workshop)
* Further discussion through workshops
* National Injury Prevention Forum in 2019
* Development of a National Health Strategy: National Injury Prevention Strategy 2019-20