



Government of **Western Australia**
Department of **Health**

Injury Prevention in Western Australia: A Review of Statewide Activity for Selected Injury Areas

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Suggested citation:

Department of Health, Western Australia. Injury prevention in Western Australia: A review of statewide activity. Perth; Chronic Disease Prevention Directorate, Department of Health. 2015.

Note on terminology:

The use of the term “Aboriginal” within this document refers to Australians of both Aboriginal and Torres Strait Islander descent. The term “Aboriginal and Torres Strait Islander” is retained where it is included as part of an already existing formal title.

Key Words:

Injury prevention, injuries, poisoning, falls, drowning, road crashes, suicide, interpersonal violence, burns and scalds.

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Executive summary

Most injuries have the potential to be anticipated, and therefore could be avoided. The purpose of this report is to provide a resource to highlight priority areas for injury prevention in Western Australia, to report descriptive information on the extent and nature of the injury area, and to provide a snapshot of current injury prevention activity and the stakeholders who participate in the injury field. Relevant legislation for each area of injury is also identified.

Leading injury prevention types selected for review include: road crashes, falls prevention in older people, falls prevention in children, suicide, interpersonal violence, poisoning in children, burns and scalds, and drowning. Aboriginal people and injury prevention, as well as alcohol use and injury prevention are also addressed.

The leading causes of injury deaths and hospitalisations in Western Australia include injury from falls, interpersonal violence, suicide, transport, poisoning, burns and scalds and drowning (table 1 and table 2). Injuries from road crashes are among the top three causes of injury for deaths and hospitalisations across people of all ages in WA, and falls are the leading cause of death and hospitalisation for people aged over 65 years.

Table 1: **Top five causes of all avoidable deaths caused by injury for WA residents, by age group (years), 2007–2011⁽¹⁾**

Rank	0–14	15–24	25–64	65+
1	Transport ^(a)	Transport ^(a)	Intentional self-harm ^(b)	Falls
2	Drowning	Intentional self-harm ^(b)	Transport ^(a)	Intentional self-harm ^(b)
3	Assault ^(d)	Poisoning ^(c)	Poisoning ^(c)	Transport ^(a)
4	Other unintentional ^(e)	Assault ^(d)	Falls	Drowning
5	Smoke, fires, flames	Drowning	Assault ^(d)	Poisoning ^(c)

(a) Transport includes those sustained by occupants of motor vehicles and pedal cyclists.

(b) Intentional self-harm includes self-poisoning by poisons and motor vehicle exhaust; and self-harm by sharp object.

(c) Poisoning includes accidental poisoning by other and unspecified drugs, medicaments and biological substances; and drugs, medicaments and biological substances causing adverse effects in therapeutic use.

(d) Assault deaths and injuries include those caused by bodily force, sharp objects and blunt objects. Assault injuries also include sexual assault caused by bodily force

(e) Other unintentional deaths and injuries include caused by objects that cut or pierce, by other people, and by animals; accidents caused by being hit, struck or crushed by objects; and accidents caused by exposure to other and unspecified factors.

Table 2: **Top five causes of all hospitalised injury for WA residents, by age group (years), 2008–2012⁽²⁾**

Rank	0–4	5–14	15–24	25–64	65+
1	Falls	Falls	Other unintentional ^(a)	Other unintentional ^(a)	Falls
2	Other unintentional ^(a)	Other unintentional ^(a)	Transport ^(c)	Falls	Other unintentional ^(a)
3	Poisoning ^(b)	Transport ^(c)	Falls	Transport ^(c)	Transport ^(c)
4	Smoke, fires, flames and hot surfaces	Poisoning ^(b)	Assault ^(d)	Assault ^(d)	Poisoning ^(b)
5	Transport ^(c)	Smoke, fires, flames and hot surfaces	Intentional self-harm ^(e)	Intentional self-harm ^(e)	Intentional self-harm ^(e)

- (a) Other unintentional injury includes accidents caused by objects that cut or pierce, by other people, and by animals; accidents caused by being hit, struck or crushed by objects; and accidents caused by exposure to other and unspecified factors.
- (b) Poisoning injuries include accidental poisoning by other and unspecified drugs, medicaments and biological substances; and drugs, medicaments and biological substances causing adverse effects in therapeutic use.
- (c) Transport injuries include those sustained by occupants of motor vehicles and pedal cyclists.
- (d) Assault injuries include those caused by bodily force, sharp objects and blunt objects; and sexual assault caused by bodily force.
- (e) Intentional self-harm includes self-poisoning by poisons and motor vehicle exhaust; and self-harm by sharp object.

Road Crashes

- Road safety measures including seat belt wearing, speed control and alcohol control have resulted in declining rates of deaths from road crashes in WA from a peak in the 1970s.⁽³⁾⁽⁴⁾ Since 2000, the burden of road injury has shifted from deaths to serious injury and subsequent disability.⁽⁵⁾
- Road crashes most commonly result in injuries to drivers and passengers in cars. (6) The rate of deaths from motorcycle crashes in WA is rising.⁽⁶⁾ Driving or riding after drinking alcohol greatly increases the risks of a road crash.⁽⁷⁾
- Men are almost three times as likely to die and more than two and a half times as likely to be hospitalised due to road crashes as women in WA⁽⁸⁾ with alcohol, speed and greater use of motorcycles identified as contributors to this difference.⁽⁷⁾
- *Towards Zero*, the WA Road Safety Strategy aims to improve road safety through: safe road use; safe roads and roadsides; safe speeds; and safe vehicles.⁽³⁾

Falls Prevention in Older People

- The most common setting for falls in older people is at home or in residential aged care facilities.⁽⁹⁾
- Older people who fall may experience not only physical injuries but also confusion, immobilisation and depression that may in turn lead to a further restriction in daily activities.⁽¹⁰⁾
- Interventions to prevention falls in WA target older people in the community who are well and specific groups at increased risk of falls.⁽¹¹⁾
- Exercise programs and interventions to improve home safety are effective in promoting protective factors and reducing risk factors for falls among older people.⁽¹²⁾

Falls Prevention in Children

- A child's age and developmental stage influences the activities and environments where falls injuries occur and most children fall many times in their lives without incurring damage, other than a few incidental cuts and bruises.⁽¹³⁾
- Falls that result in injuries commonly occur at home, in playgrounds, from trampolines, or involve skateboards and other transport devices.⁽¹⁴⁾
- Boys have a 50 per cent higher rate of falls injuries compared with girls in WA.⁽¹⁵⁾
- Creating safer environments in WA to prevent injuries from falls in the home and from playground equipment are priorities for injury prevention for children 0–14 years.⁽¹⁶⁾

Suicide

- When people deliberately harm themselves, family members, friends, work colleagues and others in the community are affected.⁽¹⁷⁾
- Aboriginal people experience suicide within their communities at approximately twice the rate of the rest of the Australian population.⁽¹⁸⁾
- Suicide prevention involves approaches to strengthen protective factors and reduce risk factors that contribute to poor mental health and wellbeing.⁽¹⁹⁾
- Prevention activities may involve: the whole community; communities and groups that are most at risk of suicide; and individuals at risk of suicide.⁽¹⁹⁾

Interpersonal violence

- Interpersonal violence is experienced by children, adolescents, women and men and may involve intimate partner violence, sexual violence, child maltreatment, youth violence and elder abuse.⁽²⁰⁾
- Alcohol and drug use are deeply entwined with violence in the Australian community.⁽²¹⁾
- Young men and women aged 18–24 years in WA experience high rates of violence⁽²⁰⁾ and rates of death and hospitalisation due to interpersonal violence are much higher among Aboriginal people compared with non-Aboriginal people.⁽⁸⁾
- Violence prevention activities support Aboriginal people, women, children, and young men, as well as address community-wide initiatives.⁽²¹⁾

Poisoning in Children

- Infants and toddlers in WA have the highest risk of being hospitalised as a result of poisoning but very few of these injuries among 0–4 year olds lead to death.⁽⁸⁾
- Poisoning usually occurs in the home and the most common agents involved in childhood poisoning are pharmaceuticals and household products.⁽²²⁾
- Initiatives in WA to prevent poisoning in children include: requirements for child-resistant packaging; promotion of safe storage at all times of medications and household products; and access to support from the WA Poisons Information Centre.⁽¹⁶⁾

Burns and scalds

- People at higher risk of burn and scald injuries in WA are young children, men aged 25–44 years, Aboriginal people and older adults.⁽⁸⁾
- More than half of the injuries from burns and scalds in WA happen in the home and are particularly associated with cooking and hot drinks.⁽²³⁾ Injuries that result in death from burns are most commonly caused by fire in a building.⁽⁸⁾

- Burns prevention strategies combine legislation for smoke alarms, reduced fire risk cigarettes, controls on water temperatures, specific materials used in children’s clothing and education.⁽¹³⁾

Drowning

- Coastal locations (ocean and beach), home swimming pools, rivers, lakes and dams are the most common sites for fatal and non-fatal drowning in WA.⁽²⁴⁾
- Males are around twice as likely to drown and twice as likely to be hospitalised from non-fatal drowning as females and the rate of drowning among Aboriginal people is more than four times greater than non-Aboriginal people in WA.⁽⁸⁾
- Key priority areas in drowning prevention include: taking a life stages perspective; targeting high risk locations; and focusing on key drowning challenges.⁽²⁵⁾

Aboriginal People and Injury Prevention

- Compared with non-Aboriginal people, Aboriginal people in WA have much higher rates for injuries from interpersonal violence, falls, drowning, burns, suicide, poisoning, and road crashes.⁽⁸⁾
- Factors influencing the disparity in health and injury status in Aboriginal communities include the social, environmental and historical circumstances that have occurred over generations.⁽²⁶⁾
- Strategies for injury prevention among Aboriginal people focus on strength-based approaches to ensure policies and programs improve health, social and emotional wellbeing, build resilience and promote positive health behaviours.⁽²⁷⁾

Alcohol and Injury Prevention

- Alcohol makes a significant contribution to injuries among Western Australians⁽²⁸⁾ with the role of alcohol in injuries from road crashes, interpersonal violence, suicide, drowning, poisoning, falls, burns and scalds noted in this report.
- Efforts to reduce drinking both on a population level and an individual level are important in reducing alcohol-related injury.⁽²⁹⁾
- In WA the number of young people aged 12–17 years who had never consumed alcohol has increased significantly between 1993 and 2011.⁽³⁰⁾
- Approaches to reduce alcohol-related injury include:
 - community-wide strategies relating to the price, availability and marketing of alcohol
 - targeted programs that focus on specific settings or population groups;
 - promotion of alternative activities not connected to alcohol
 - encouragement for individuals to reduce their alcohol consumption.

WA Health’s strategic directions and priorities for the prevention of avoidable injury by facilitating improvements in health behaviours and environments are outlined in the Western Australian Health Promotion Strategic Framework 2012–2016.⁽³¹⁾

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1. Introduction

Injuries were the fourth most common cause of death in WA between 2007 and 2011 and the fourth most common specific cause of hospitalisation between 2008 and 2012. For males, injuries ranked third as a specific cause of death after cancer and cardiovascular diseases and female injuries ranked fifth after cancer, cardiovascular diseases, respiratory diseases and neurological diseases.⁽¹⁾

The Australian Burden of Disease Study reported injuries were the third largest contributor to fatal burden of disease in 2010 and were the leading cause of fatal burden in people aged under 45 in Australia.⁽³⁾

WA Health is committed to reducing the incidence of avoidable injury by facilitating improvements in health behaviours and environments. A range of partners including WA Health, other government and non-government agencies, share the goal of improving community safety in Western Australia. In some areas WA Health takes a lead role, but in areas led by other agencies-such as road safety, occupational health and safety, product safety and crime prevention – WA Health provides support by offering a skills base, models of practice, and data provision and analysis.⁽²⁾

Strategies to encourage healthier and safer populations require a sustained and long term investment in health promotion and an integrated approach which takes into account the wider socioeconomic, cultural and environmental conditions which shape behaviour. The Western Australian Health Promotion Strategic Framework 2012–2016 sets out WA Health’s strategic directions and priorities for the prevention of avoidable chronic disease and injury.⁽²⁾

Strategic Directions:

- Healthypolicies
- Legislation and regulation
- Economicinterventions
- Supportiveenvironments
- Publicawareness and engagement
- Communitydevelopment
- Targetedinterventions
- Strategiccoordination, buildingpartnerships and capacity building.

This review covers areas of injury prevention with the highest rates of hospitalisation and death including road crashes, falls, suicide, interpersonal violence, poisoning, drowning, burns and scalds and a risk factor (alcohol) that is a contributing factor to nearly one in five deaths and one in eight hospitalisations and injury prevention among Aboriginal people.

Injury prevention areas are defined and chapters include:

1. Overview
2. Risk and protective factors
 - 2.1 Environmental factors
 - 2.2 Individual factors
 - 2.3 Socioeconomic characteristics
 - 2.4 Health behaviours

3. Key stakeholders in WA
4. Current activities in WA
5. Legislation, standards and codes of practice
6. Conclusion
7. References

This report – Injury Prevention in Western Australia: A Review of Statewide Activity (2015) – updates the previous report, ‘Injury in Western Australia: A review of best practice, stakeholder activity, legislation and recommendations for selected injury areas’, published in 2002. The intention of this report is to provide a resource to support people, communities and organisations engaged in injury prevention in Western Australia.

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2. Road Crashes

Definition:

The majority of transport related injuries are from land transport – traffic and off-road use of motor vehicles, motorcycles and bicycles as well as pedestrian activity that is identified in this section as road crashes.

Intentional injuries from road crashes are not covered in this discussion.

2.1 Overview

Since the 1970s the number of deaths from road crashes in WA has halved, while at the same time the population has nearly doubled.⁽¹⁾ Road safety measures credited with this improvement are seat belt wearing, speed control and alcohol control with lower legal limits and road-side testing of blood alcohol levels in drivers.⁽²⁾

Technological and safety advances in car design also reduce the risks of death or serious injury in a crash. The risks of death or serious injury in Australia for people involved in a crash in a car made after 2007 is about half the risk experienced by people who crash in a car made in 1987.⁽³⁾

The rate of injury from road crashes leading to hospitalisation has not changed significantly in WA or Australia since 2000.⁽⁴⁾⁽⁵⁾ However, during the five year period between 2008 and 2012 the male rate of hospitalisation from road crashes has decreased significantly.⁽⁴⁾ The Safe System approach for road safety aims to provide a road system that increasingly prioritises safety outcomes to cater for the mistakes people make.⁽¹⁾

Behaviour by road users is very important to road safety. The Towards Zero WA road safety strategy⁽¹⁾ notes that:

“Many people believe it is mostly risk taking behaviours (mainly by young males) that cause road deaths. While this is true in some cases, it is not the whole story, with the majority of young drivers crashing simply due to a lack of experience.

The evidence also tells us that it is not only ‘risk taking’ behaviour that causes serious crashes – many are caused by the mistakes drivers and riders make, such as errors of judgement or momentary lapses of concentration.

To make substantial reductions in injury crashes, we need to continue to target ‘risk taking’ but we also need to address inadvertent road user errors that may contribute up to 50 per cent of all serious crashes.”

2.2 Risk and Protective Factors

2.2.1 Environmental factors

Cars, motorcycles, bicycles and pedestrians

Three quarters of serious crashes in WA involve drivers or passengers in cars.⁽⁶⁾ In Australia the rate of serious injury in terms of vehicle kilometres travelled for motorcyclists is 38 times that for people travelling in cars.⁽⁷⁾ Motorcycle crashes make up approximately 12% of fatal and serious crashes in WA⁽⁶⁾ and the rate of deaths from motorcycle crashes in WA is rising with increasing numbers of people in WA riding motorcycles and scooters.⁽⁸⁾

Four per cent of serious crashes in WA involve bicyclists and there are around three deaths per year.⁽⁶⁾ In Australia bicycling is responsible for 38 per cent of serious injuries from crashes for 5–17 year olds (the majority on roadways) and 32 per cent of 0–4 years (commonly at home) compared with 11 per cent of adults over 18.⁽⁷⁾

Approximately 14 per cent of all road fatalities and 8 per cent of hospitalisations for road crash injuries in WA are pedestrians.⁽²³⁾ Those who are particularly vulnerable to injury as pedestrians include children aged less than 14 years, people older than 60 years, adult men, Aboriginal people, as well as those who have consumed alcohol above the recommended levels.⁽⁹⁾

Legislation

There is strong evidence that legislation requiring the wearing of seat belts, limits on speed and blood alcohol levels and the road-side monitoring and enforcement of these laws, are effective measures to reduce road crash deaths.⁽¹⁰⁾ The compulsory wearing of helmets by motorcyclists is supported by evidence that helmets reduce the risk of death and head injury in motorcycle riders who crash.⁽¹¹⁾ Reviews of bicycle helmet legislation show the effectiveness of laws in increasing helmet use and decreasing head injury rates.⁽¹²⁾

Roads and roadsides

Road safety research has identified measures that can reduce road crashes:⁽³⁾

- design of intersections to add roundabouts or a right turn lane
- building sealed shoulders or shoulder edges on rural roads
- use of barriers to separate traffic
- improving roads in Aboriginal communities
- lowering speed limits on the approaches to intersections.

2.2.2 Individual factors

Gender

Men are almost three times as likely to die and two and a half times more likely to be hospitalised due to road crashes as women in WA⁽⁴⁾ with alcohol, speed and greater use of motorcycles identified as contributors to this difference.⁽⁹⁾

Age and development

In WA deaths and hospitalisations from road crashes are highest among adolescents and those aged 25–44 years.⁽⁴⁾ Among WA children aged 16 years or less who were killed or seriously injured in 2012, 52 per cent were passengers in vehicles and 21 per cent were pedestrians.⁽⁶⁾

Twenty two per cent of people killed as a result of road related crashes in WA during 2012 were aged between 17 and 24 years.⁽⁶⁾ Factors that contribute to crashes by novice drivers include poor decision making, inexperience, influence of peer passenger, risk taking behaviour, and alcohol and drug use.⁽¹³⁾⁽¹⁴⁾

Ethnicity

The rate of deaths from road crashes among Aboriginal people is nearly five times greater than non-Aboriginal people in WA and Aboriginal people are almost twice as likely to be hospitalised.⁽⁴⁾ Since 1971, the rates of road injury involving Aboriginal people have been increasing while the rates for non-Aboriginal people have been decreasing. Higher rates of unlicensed driving, not wearing seat belts, drink driving, pedestrian collisions and unsafe travel, such as riding in the back of trucks and utilities by Aboriginal people compared with non-Aboriginal people, have been identified as factors.⁽¹⁵⁾

2.2.3 Socioeconomic characteristics

Residents of the most disadvantaged areas in WA are more than twice as likely to die or be hospitalised due to injuries from road crashes.⁽²³⁾ It has been suggested that these differences come mainly from variations in exposure to risk, rather than in behaviour, though behavioural differences do play some role.⁽¹³⁾

2.2.4 Health behaviours

Alcohol and other drugs

Driving or riding after drinking alcohol greatly increases the risks of a road crash. A person is two times more likely to crash with a blood alcohol concentration (BAC) of 0.05; seven times more likely to crash with a BAC of 0.08; and 25 times more likely with a BAC of 0.15. In WA in 2011/12, more than 15,000 people were found to be driving or riding with a BAC above the legal limits. Although there may be a perception that drink driving is mainly a problem among young people, the highest proportions of drivers/riders with illegal BACs dying in road crashes are men in their thirties and forties.⁽⁹⁾

Use of drugs other than alcohol by drivers is estimated to cause 7 per cent of all road deaths.⁽³⁾ The drugs of major concern from a road safety perspective are cannabis, amphetamine type stimulants including methylamphetamine ('speed' or 'ice') and MDMA ('ecstasy').⁽⁹⁾

Speeding

Speeding is not only driving above the posted speed limit, but also includes driving too fast for the road conditions (i.e. weather, time of day and traffic). Travelling at 65 km/h in a 60 km/h speed zone doubles the chance of having a crash resulting in injury and travelling at 80 km/h in a 60 km/h speed zone increases this chance by 32 times. The reduction of the urban default limit in WA from 60 km/h to 50 km/h has demonstrated positive outcomes leading to 20 per cent reduction in crashes. Speed was a contributing factor in 25 per cent of road crash deaths in WA during 2012. The vast majority (81%) of drivers and riders involved in fatal speed-related crashes were males, almost all of whom were 17 to 39 years old.⁽⁹⁾

Seatbelts

Drivers and passengers are 10 times more likely to be killed in a road crash if they are not wearing a seat belt in a car. Every year around 38 people are killed in road crashes in WA while not wearing a seat belt. Only 26 per cent of the State's population live in regional or remote WA, yet 65 per cent of the fatal and serious injuries where a seat belt was not worn occurred in these areas.⁽⁹⁾ High risk behaviours such as increased BAC levels and higher speed, lower the likelihood of wearing a restraint.⁽¹⁶⁾

Fatigue and distractions

Fatigue is estimated to be responsible for 20–30 per cent of all road deaths.⁽³⁾ The reaction time of a driver who has been awake for 17–19 hours is similar to the reaction time of a driver with a blood alcohol concentration (BAC) of 0.05. Risks are greatest between 1am and 6am when driver alertness is low.⁽⁹⁾

Using a mobile phone while driving impacts on driving performance and increases the risk of being involved in a crash by up to four times. Sending a text message is more distracting than talking on a mobile phone.⁽⁹⁾

2.3 Key Stakeholders in WA

State Government

Office of Road Safety [Towards Zero: Getting there together](#)

Western Australia Police [Traffic](#)

Main Roads Western Australia [Road Safety](#)

Department of Transport [Licensing Active Transport Cycling](#)

Department of Planning [Plans and policies](#)

Department of Health [Injury Prevention](#)

Department of Education [School Drug Education & Road Aware \(SDERA\)](#)

Drug and Alcohol Office [Resources](#)

Insurance Commission of Western Australia [Compulsory third party insurance](#)

Other

Road Safety Council [Road Safety Council](#)

Royal Automobile Club of Western Australia [Road safety and transport](#)

Western Australian Local Government Association [RoadWise](#)

Kidsafe WA [Road safety](#)

Injury Control Council WA [Road Trauma Support WA](#)

Australasian College of Road Safety [ACRS](#)

Research

Department of Infrastructure and Regional Development (Australian Government)

[Bureau of Infrastructure, Transport and Regional Economics](#)

Monash University Injury Research Institute [Monash University Accident Research Centre](#)

Main Roads WA [Driver speed behaviour on WA roads Black spot program evaluation](#)

Australian Indigenous HealthInfo Net [Road safety](#)

2.4 Current Activities in WA

Towards Zero, the WA Road Safety Strategy⁽¹⁾ to reduce road trauma in Western Australia 2008–2020 is aligned closely with the National Road Safety Strategy 2011–2010, and consistent with a UN Global Plan proclaiming 2011 to 2020 as the Decade of Action for Road Safety.⁽³⁾

Towards Zero aims to improve road safety through four cornerstones:

Safe Road Use – Improving road user behaviour

Safe Roads and Roadsides – Improving road infrastructure improvements

Safe Speeds – Ensuring speed limits and travel speeds are appropriate for the safety of the road infrastructure

Safe Vehicles – Improving the safety of the vehicles on the road.

Towards Zero is supported by:

- WA Road Safety Council whose role is to provide evidence based, independent advice on road safety problems and to engage and develop partnerships with the community and business to facilitate wide support for implementation⁽¹⁷⁾
- Local road safety committees and a state-wide network of groups and individuals with an interest in road safety including representatives from Local Government, Government agencies, local businesses, community groups and individuals are supported by WALGA's RoadWise Program⁽¹⁸⁾

Injury Prevention in WA: A Review of Statewide Activity of Selected Injury Areas

- A road safety education action plan that targets young road users aged from birth to 18 years and their parents/carers⁽¹⁹⁾
- The Road Trauma Support WA project coordinated by the Injury Control Council of WA (ICCWA) to build capacity for stakeholders in reducing road trauma in WA.⁽²⁰⁾

Focus area	Target	Programs, campaigns and resources
Road users	Children	Department of Education SDERA Smart steps Kidsafe WA Driveway safety Office of Road Safety Children road safety WALGA RoadWise Road Safety Around Schools WA Police Constable Care Getting to school SDERA Challenges and choices K–10 RAC bstreetsmart Y10–12 Pedestrian Council Aust Walk safely to school day
Pedestrians	Community-wide	Kidsafe WA Pedestrians Office of Road Safety Pedestrian safety Department of Transport Active transport: TravelSmart LivingSmart Main Roads WA Pedestrians and cyclists Pedestrian Council Aust National walk to work day
Road users	Children	Bicycling Western Australia Riding to school Kidsafe WA Bicycles skateboards skates scooters SDERA Challenges and choices K–10
Cyclists	Community-wide	Office of Road Safety Cyclists Department of Transport Cycling Cycle instead WA Bicycle Network Plan Westcycle Safety Bicycling Western Australia Better biking Cycling WA Be active bike skills Main Roads WA Pedestrians and cyclists RAC Cycling Amy Gillett Foundation Cycle Safe Communities a metre matters It's a two way street
Road users	Community-wide	Department of Transport Ride safe handbook Office of Road Safety Motorcyclists & scooter riders RAC Motorcycle and Scooter safety
Road users	Community-wide:	Office of Road Safety Campaigns and programs RAC Safe drivers Department of Transport Driver safety WA Police Traffic
Drivers & Passengers	Drink Driving Speeding Fatigue Distractions Drug Driving Seat Belts	Office of Road Safety Seatbelts and child restraints WALGA RoadWise Child car restraints Kidsafe WA Child car restraints

Focus area	Target	Programs, campaigns and resources
Road users Drivers	Learners and novices Regional Aboriginal Older adults Visitors to WA	Department of Transport Drive safe handbook Department of Education SDERA Keys for life RAC Learning to drive RAC Resilient Drivers Program Y10–12 Office of Road Safety Novice drivers WALGA RoadWise Novice drivers WALGA RoadWise Office of Road Safety Indigenous road safety WALGA RoadWise Indigenous road safety Office of Road Safety Seniors RAC Community education seniors Office of Road Safety Visitors to WA
Safe roads and roadsides		Main Roads WA Road Safety RAC Road Assessment Program (AusRAP) WALGA RoadWise Road Safety Around Schools WA Police Children's Crossings WALGA RoadWise Making roads motorcycle friendly Australian Bicycle Council National cycling strategy Department of Planning Liveable neighbourhoods
Safe speeds		WALGA RoadWise Safe speeds WA Police Road safety
Safe vehicles		Department of Transport Licensing RAC Safe cars Office of Road Safety Safer cars Fleet safety WALGA RoadWise Safe vehicles

2.5 Legislation, Standards and Codes of Practice

WA road rules largely mirror the Australian Road Rules (ARRs) approved by all State and Territory Transport Ministers.⁽²¹⁾

Road Traffic Act 1974	Vehicle licenses, driver's licenses, driving offences, alcohol and drug related driving offences
Road Traffic Code 2000	Speed restrictions, traffic rules, pedestrians, cyclists, seatbelts & child restraints
WA Legislation	Carriage of additional passengers where there are no seat belts or child restraints
WA Legislation	License conditions for novice drivers (a person is a Novice Driver until they have held a driver's licence for at least two (2) years or periods adding up to two (2) years)
AS/NZS 1754:2013 Mandatory Australian standards	Child restraint standards

AS/NZS 1698:2006 Amendment No. 1 28 Sept 2007 Amendment No. 2 27 May 2009 Mandatory Australian standards	Motorcycle helmets come under standard Protective Helmets For Vehicle Users
Speed restrictions, traffic rules, pedestrians, cyclists, seatbelts & child restraints	Bicycle Helmets

Sources:

- WA State Law Publisher www.slp.wa.gov.au
- WA Office of Road Safety www.ors.wa.gov.au
- WA Department of Transport www.transport.wa.gov.au
- Standards Australia www.standards.org.au

2.6 Conclusion

Measures introduced through a multidisciplinary and intersectoral approach, taken in Australia to prevent injuries from road crashes, have been credited with successes in reducing road deaths. Over the past decade, however, the burden of road injury has shifted from deaths to serious injury and subsequent disability.⁽²²⁾

Full implementation of the Towards Zero strategy in WA is estimated to have the potential to save 11,000 people from being killed or seriously injured between 2008 and 2020.⁽¹⁾

As well as the continued current Safe System focus in Towards Zero, rapid developments in information and communication technologies for crash avoidance may provide the next generation of road safety benefits.⁽²²⁾

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3. Falls Prevention in Older People

Definition:

Falls are commonly defined as inadvertently coming to rest on the ground, floor or other lower level, excluding intentional change in position to rest in furniture, wall or other objects.⁽¹⁾ Balance is staying upright and steady when stationary, such as when standing or sitting, or during movement.⁽²⁾

3.1 Overview

One in three older people living at home in WA experience a fall each year. A fall on the same level due to slipping, tripping and stumbling is the most common cause of injury. Serious injuries include bone fractures (particularly to the hip), a head injury, bruises, or tears to the skin (lacerations) that often require hospital treatment.⁽³⁾ Over 120 people in WA aged over 65 years of age die each year from injuries following a fall while each year more than 7,000 are hospitalised.⁽³⁾⁽⁴⁾

Older people who fall may experience not only physical injuries but also confusion, immobilisation and depression that may in turn lead to a further restriction in daily activities.⁽¹⁾ This loss of independence and confidence can lead to an older person moving from home to residential care or entering residential care after leaving hospital following injuries from a fall.⁽³⁾

3.2 Risk and Protective Factors

3.2.1 Environmental factors

The most common setting for falls in older people is at home or in residential aged care facilities.⁽³⁾ The reason people fall is due to their interaction between exposure to hazards in the environment and their physical abilities and behaviour. Risk factors for falls in older people are attributed to uneven or slippery surfaces, high or narrow steps, inadequate lighting or lack of handrails on steps, poorly fitted floor coverings inside homes and cracked or slippery paths outside of the home.⁽¹⁾

Interventions to improve home safety carried out by occupational therapists or the completion of a home safety audit such as the Stay On Your Feet WA® checklist can reduce the risk of falls, especially in people at higher risk of falling.⁽⁵⁾

3.2.2 Individual factors

Gender

In WA the rate of hospitalisation due to falls is significantly higher for women aged over 55 years compared with men, while men are more likely than women to die due to falls.⁽⁴⁾

Age

The rates of hospitalisation and death due to falls rise steeply as people reach their seventies with the highest levels in WA among people over 85 years of age.⁽⁴⁾

Ethnicity

Across all age groups in WA, Aboriginal people are 2.2 times more likely to be hospitalised due to fall injuries than non-Aboriginal people and two times more likely to die from falls.⁽⁴⁾

Health status

Having had one fall is a risk factor for future falls and developing a ‘fear of falling’, which may result in reduced activity levels or sedentary behaviour that can also increase falls risk.⁽³⁾

The risk of falling is also increased by physical disability and mobility problems, vision and hearing impairment, the use of some medications, medical problems that cause sudden changes in heart rate and blood pressure, and disabling foot pain.⁽⁵⁾⁽⁶⁾

3.2.3 Socioeconomic characteristics

People living in the most disadvantaged areas in WA have higher rates of hospitalisation due to falls.⁽⁴⁾ A lack of social supports and opportunities to participate in social activities may increase the risk of falls. It is also possible that feelings of isolation and depression, which are triggered by the lack of social participation, increase the ‘fear of falling’ and vice versa.⁽¹⁾

3.2.4 Health behaviours

Physical activity programs, particularly those that incorporate balance and strength components, are effective at reducing the risk of falls.⁽⁵⁾

The use of alcohol, wearing inappropriate footwear, rushing with little attention to the environment and not using mobility devices are behaviours that increase the risk of falls.⁽¹⁾⁽⁶⁾

3.3 Key Stakeholders in WA

State government

Department of Health Chronic Disease Prevention Directorate

Department of Health [Falls Prevention Health Network](#)

Department of Health [Falls clinics and falls specialists](#)

Department of Health [Community Physiotherapy Services](#)

Department of Health [Home and Community Care](#)

Department of Health WA Country Health Service [Population Health Units](#)

Department for Local Government and Communities [Age Friendly WA Age Friendly Homes](#)

Other

Injury Control Council of WA (ICCWA) [Falls prevention](#)

Australian Commission on Safety and Quality in Health Care [Falls prevention](#)

Council on the Ageing [COTA](#)

Community health care providers [HACC service directory](#)

Residential aged care facilities [Aged care guide](#)

ICCWA [Partnership & Sector Development Program](#)

Research

Monash Injury Research Institute [Falls Prevention Research Institute](#)

Curtin Monash Accident Research Institute [Injury prevention research program](#)

3.4 Current Activities in WA

[National best practice guidelines](#) provide a framework for prevention of falls and harm from falls in older people in community care, residential aged care and hospitals.⁽⁷⁾ In Western Australia the [Falls Prevention Model of Care](#) has four areas of focus: Create a robust and healthy population; Apply falls prevention interventions; Optimize care pathways and communications; and Support the translation of research into practice.⁽⁸⁾

Injury Prevention in WA: A Review of Statewide Activity of Selected Injury Areas

Activities for the prevention of falls injuries among older people focus on programs, education and campaigns to promote and support a safer community in WA.⁽⁹⁾ There are also initiatives that align with an Age-Friendly approach that addresses environmental and social factors including: The built environment; Transport; Housing; Social participation; Respect and social inclusion; Civic participation and employment; Communication; and Community support and health services.⁽¹⁾

Focus area	Target	Programs, campaigns and resources
Safer environments	Communities Homes	Department for Local Government and Communities Age Friendly WA Age Friendly Homes Department of Health Stay On Your Feet®: Home safety Department of Health Falls Specialist Program
Exercise programs	Older adults	Council on the Ageing Living Longer Living Stronger™ Department of Health Community Physiotherapy Services
Health and well-being	Community-wide Aboriginal CaLD Hospital inpatients	Department of Health Stay On Your Feet®-resources Department of Health Stay On Your Feet®-resources Falls Risk Assessment and Management Plan
Education and training	Health professionals	Department of Health Falls prevention e-learning Department of Health Falls in Hospital – A doctor’s guide to prevention and management

3.5 Legislation, Standards and Codes of Practice

Safe housing design Mandatory Australian standards	Australian standard AS 4226–2008 Aspects relevant to falls in older people include flooring, site planning, doors and windows, and steps and stairs.
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Source:

- Standards Australia www.standards.org.au

3.6 Conclusion

WA is addressing the complex and multi-factorial nature of falls in older age with evidence-based prevention strategies and healthy public policy.⁽⁸⁾⁽⁹⁾

Current approaches focus on targeting specific groups of older people in the WA community who are at increased risk of falls and also promoting protective factors and reducing risk factors for falls among older people in the community who are well. Tailored interventions and strategies for falls prevention will benefit groups in the WA community such as Aboriginal people, people in culturally and linguistically diverse groups and people with cognitive impairment.⁽¹⁰⁾

It is important to strengthen efforts to prevent falls in older people with trends of an aging population indicating a potential increase in hospitalisations due to falls in older people.

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4. Falls Prevention in Children

Definition:

Falls are commonly defined as inadvertently coming to rest on the ground, floor or other lower level, excluding intentional change in position to rest on furniture, wall or other objects.⁽¹⁾

4.1 Overview

As children learn to walk, climb, run, jump and explore the physical environment, falling is a common occurrence and a normal part of development. Fortunately, most falls are of little consequence and most children fall many times in their lives without incurring damage, other than a few incidental cuts and bruises. For some children, their curiosity may not match their capacity to gauge or respond to the situation and some falls are beyond both the resilience of the human body and the capacity of the contact surface to absorb the energy transferred, leading to injury.⁽²⁾

Falls are the leading cause of injury among children attending the Emergency Department at Princess Margaret Hospital in Perth.⁽³⁾ Among children aged 0 to 14 years in Australia, fractures account for 62 per cent of all fall-related injuries and the forearm is the most common fracture site.⁽⁴⁾

4.2 Risk and Protective Factors

4.2.1 Environmental factors

Falls among children under 10 years of age most commonly occur in the home and are due to hazards including nursery furniture, baby walkers, tables, stools, chairs (including highchairs), beds and playground equipment (particularly trampolines).⁽⁵⁾

Playgrounds are a major source of falls risk for children, with the risks of falls injuries from climbing apparatus, slides and swings, related to the height of playground equipment and the type and depth of the surface.⁽⁶⁾ Monitoring of playgrounds in Australia where falls have resulted in fracture injuries has shown that a large number of public playgrounds do not comply with the standards for under-surfacing.⁽⁷⁾

4.2.2 Individual factors

Gender

Boys in WA have a 50 per cent higher rate of falls injuries and this may be due to gender differences in their physical and psychosocial development.⁽⁸⁾ Patterns of child-rearing, socialisation, role expectations and the amount of risk taking behaviours influence the higher number of fall-related injuries among boys.⁽²⁾

Age and development

A child's age and developmental stage influences the activities and environments where falls injuries occur as well as the characteristics of the injuries.⁽²⁾ Fall injuries among Australian children aged 0–14 years commonly involve falling from playground equipment with the highest number of injuries among children 5–9 years. Other common causes are: falls while being carried or supported (0–1 year); falling from chairs and beds (0–4 years); and falls involving skateboards (10–14 years).⁽⁵⁾ Injuries involving bicycles are considered in the section of this report on road crashes.

Ethnicity

For children aged 0–14 years in WA, Aboriginal children are 1.3 times more likely to be hospitalised due to fall injuries than non-Aboriginal children.⁽¹³⁾

4.2.3 Socioeconomic characteristics

In Australia, there are more home safety risk factors for childhood injury linked to the low socioeconomic status indicators of low income; low education and low employment. However, higher socioeconomic status households had more risk factors relating to play equipment.⁽¹⁰⁾

4.2.4 Health behaviours

Playing in natural environments assists with building children’s motor skills and where there are features that provide diverse functions, play can improve balance and coordination abilities among children.⁽¹¹⁾

While it is recommended that pre-school aged children are supervised constantly, fall-related injuries still occur, so supervision should be combined with other strategies to create safer homes and play environments.⁽²⁾

4.3 Key Stakeholders in WA

State government

Department of Health [Injury Prevention](#)

Department of Health [Public and Population Health Units](#)

Department of Health WA Country Health Service [Population Health Units](#)

Other

Kidsafe WA [Kidsafe WA](#)

Australian Competition and Consumer Commission [Product Safety Australia](#)

Injury Control Council of WA [ICCWA](#)

Nature Play WA [Nature Play WA](#)

4.4 Current Activities in WA

Activities for the prevention of falls injuries among children focus on programs, education and campaigns to promote and support a safer community in WA.⁽¹²⁾

Focus area	Target	Programs, campaigns and resources
Safer environments	Homes	Kidsafe WA Home safety Safety in the home resources Australian Competition and Consumer Commission Keeping baby safe guide to infant and nursery products Product Safety Australia Baby and nursery
	Schools and Playgrounds	Kidsafe WA Playgrounds Safety in schools Nature Play WA Nature playgrounds PHAIWA Children’s environment and health report card project
Education and training	Community-wide	Kidsafe WA Falls can be prevented safety campaign
	Aboriginal CaLD	Kidsafe WA Publications

4.5 Legislation, Standards and Codes of Practice

Child safety guidelines Handbook from Standards Australia and Standards New Zealand	HB 136:2004: Safety aspects – Guidelines for child safety Provides regulatory authorities, manufacturers, and consumers with the principles for a systematic approach to addressing hazards, and specific developmental characteristics of children that place them at risk of injury and identify hazards across a broad range of products used in domestic situations, restaurants, nurseries and institutions.
Safe housing design Mandatory Australian standards	Australian standard AS 4226–2008 Aspects relevant to falls in children include flooring, site planning (children’s outdoor play spaces, garbage chutes), doors and windows, and steps and stairs.

<p>Furniture Mandatory Australian standards</p>	<p>AS 4684–2009 High chairs Specifies safety requirements for freestanding high chairs including design, construction, performance, labelling and marking.</p> <p>AS/NZS 2172:2013 Cots for household use Specifies material, construction and design requirements for cots as well as performance criteria, labelling and marking requirements.</p> <p>AS/NZS 2195:2010 Folding cots Specifies safety requirements for folding cots, accessories used with folding cots and playpens with a floor constructed of metal, plastic, textile fabric or mesh. For timber folding cots or cots made with rigid materials, reference is made to AS/NZS 2172. Standard is not applicable to cradles, carry cots, non-folding cots or playpens without a floor.</p> <p>AS/NZS 4220:2010 Bunk beds and other elevated beds Essential safety requirements for bunk beds and other elevated beds used in domestic situations, nurseries and institutions, and functional durability, stability and performance criteria.</p>
<p>Playgrounds Mandatory Australian standards</p>	<p>AS 4685.1:2014 Playground equipment General safety requirements for playground equipment covering materials, design and manufacture.</p> <p>AS 4685.2:2014 Swings</p> <p>AS 4685.3:2014 Slides</p> <p>AS 4685.4:2014 Runways</p> <p>AS 4685.5:2014 Carousels</p> <p>AS 4685.6:2014 Rocking equipment</p> <p>AS 4685.11:2014 Spatial network</p> <p>AS 4989–2006/Amdt 2–2010 Trampoline</p> <p>AS 4422–1996/Amdt 1–1999 Playground surfacing Requirements for surfacing to be used in children’s playgrounds and specific requirements for areas where impact energy attenuation is necessary.</p> <p>AS/NZS 4486.1:1997 Playgrounds and playground equipment – Development, installation, inspection, maintenance and operation</p> <p>AS/NZS ISO 8124.6:2011 Swings, slides and similar activity toys for indoor and outdoor family domestic use Requirements and test methods for activity toys for domestic family use intended for children under 14 years to play on or in.</p>

Prams Mandatory Australian standards	AS/NZS 2088:2013 Prams and strollers Specifies materials, construction, performance and labelling requirements and test methods for prams, strollers and their accessories.
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Sources:

- Western Australian Consolidated Regulations, Building Regulations 2012
www.austlii.edu.au/au/legis/wa/consol_reg/br2012200/
- Standards Australia www.standards.org.au

4.6 Conclusion

Strategies to promote protective factors and reduce risk factors for injuries from falls among children recognise that while falls are commonplace, injuries from falls can be prevented.⁽²⁾

There has been a significant increase in the rate of hospitalisations due to falls among Western Australian children 0–14 years between 2008 and 2012.⁽¹³⁾

Creating safer environments in WA to prevent injuries from falls in the home from chairs, beds, and other furniture and from playground equipment are priorities for children 0–14 years and involve partnerships between injury prevention bodies, Standards Australia, building authorities, playground developers and local governments.⁽⁷⁾

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5. Suicide and Intentional Injuries

Definition:

'Acts of intentional self-poisoning or self-injury whatever the apparent purpose of the act' are considered in this section.⁽¹⁾ An alternative term used is deliberate self-harm (DSH) that includes self-injury together with suicidal behaviours such as suicide attempts.⁽²⁾

5.1 Overview

More than 300 people take their own life each year in WA⁽³⁾ and over 2,500 more people are admitted to hospital each year from deliberate self-harm.⁽⁴⁾

Suicide impacts negatively on the quality of life of individuals and families and has ongoing implications for communities. Aboriginal people are overrepresented in this injury type and experience suicide within their communities at approximately twice the rate of the rest of the Australian population.⁽⁵⁾

Preventing acts of intentional self-poisoning or self-injury involves approaches to strengthen protective factors and reduce risk factors that contribute to poor mental health and wellbeing.⁽⁶⁾ Normalising and discussing mental health problems within society improves people's understanding of this issue.

5.2 Risk and Protective Factors

5.2.1 Good mental health

Protective factors such as positive personal relationships, personal belief system and coping strategies contribute to increased self-esteem and positive mental health.⁽⁷⁾

In Aboriginal communities the concept of 'social and emotional well-being' is seen as more appropriate than 'mental health' as used in non-Aboriginal settings. Supportive environments in Aboriginal communities typically include families, schools and organisations that support each other in placing a high value on social and emotional development, particularly of children.⁽⁵⁾

5.2.2 Environmental

Rates of suicide rise with increasing remoteness and compared with major cities, residents of very remote WA have a 40 per cent increased risk of suicide.⁽²⁰⁾

5.2.3 Individual

Age

Rates of deaths from suicide peak among men and women in WA in the 25–29 year age group. Among WA men, the rate of suicide declines slowly through middle age and then a second peak is seen in the rate for men aged 85 years and over. Rates are relatively constant for WA women from the age of 30 onwards.⁽²⁰⁾ Aboriginal people take their own lives at younger ages than non-Aboriginal people, with the majority of suicide deaths occurring before the age of 35 years.⁽⁸⁾

Gender

Deaths from suicide are more than three times higher for men than women, with 1,097 deaths compared to 313 deaths between 2007–2011 respectively in WA.⁽⁴⁾ Life events such as relationship breakdowns, mental illness, substance misuse, conflict with family or friends, financial issues and physical illness are commonly reported as stressors for WA men who died due to suicide. For women similar stressors are reported as males although mental illness, the death of someone close and childhood abuse are reported more frequently.⁽⁹⁾ Women are more

likely to be hospitalised due to self-harm with age standardised rates of 165 compared with 94 per 100,000 population for men in 2012.⁽⁴⁾

Aboriginal people

Aboriginal people are 2.3 times more likely to die due to suicide than non-Aboriginal people. Among young adults the rates of suicide among Aboriginal men and women are four to five times higher than the rate for non-Aboriginal men and women.⁽⁸⁾ The interconnected issues of cultural dislocation, personal trauma and the ongoing stresses of disadvantage, racism, alienation and exclusion are acknowledged as contributing to the heightened risk of mental health problems, substance misuse and suicide among Aboriginal people.⁽¹⁰⁾

Lesbian, Gay, Bisexual, Transexual and Intersex (LGBTI) communities

Suicide attempts and self-harm rates among Lesbian, Gay, Bisexual, Transexual and Intersex communities are significantly higher than among non-LGBTI populations. Sexual orientation and gender identity alone do not necessarily elevate risk; rather, experiences of heterosexism, homophobia and transphobia are known to contribute to social isolation, poorer mental health outcomes, substance misuse, and other sociocultural and economic problems and conditions, which in turn place LGBTI individuals at greater risk of suicide and self-harm.⁽¹¹⁾

People with mental health and substance use issues

People who experience mental health problems (such as depression and anxiety) and other mental illnesses are at a higher risk of suicide and self-injury. Among people who have substance use problems there are also higher risks of engagement in self-harm.⁽⁷⁾⁽¹²⁾ People who self-injure (commonly cutting, scratching, burning or hitting themselves) are more likely to have a mental health condition, more likely to misuse substances, more likely to have had suicidal thoughts, and more likely to have attempted suicide in the preceding 12 months.⁽²⁾

The rate of suicide among people who experienced sexual abuse as children is significantly higher than in the general population and can be related to experiencing higher levels of anxiety.⁽¹³⁾

5.2.4 Socioeconomic characteristics

Men who live in the most disadvantaged areas of WA are twice as likely to die from suicide compared with men living in the least disadvantaged areas. There is no difference in the death rate for women across all socioeconomic groups. However both men and women in the most disadvantaged areas are more likely to be hospitalised from self-harm.⁽²⁰⁾

5.3 Key Stakeholders in WA

State Government

Mental Health Commission [Mental Health Commission](#)

Department of Health [Mental health services: metropolitan, country, child and adolescent](#)

Department of Health [Aboriginal Health](#)

Department of Child Protection and Family Support [Crisis Care](#)

Department of Health WA Country Health Service [Population Health Units](#)

Other

Commonwealth Department of Health [Mental health](#)
 beyondblue [beyondblue](#)
 Black Dog Institute [Black Dog](#)
 Headspace [Headspace](#)
 Lifeline [Lifeline](#)
 Suicide Prevention Australia [Suicide Prevention Australia](#)
 WA Association for Mental Health [Mental health promotion](#)
 Youth Focus [Youth Focus](#)

Research

Australian Bureau of Statistics [Suicides, Australia](#)
 Department of Health [WA Centre for Mental Health Policy Research](#)
 Griffith University [Australian Institute for Suicide Research and Prevention](#)
 National Health and Medical Research Council [Centre of Research Excellence in Suicide Prevention](#)
 University of Queensland [Centre for Suicide Prevention Studies](#)

5.4 Current Activities in WA

National strategies for improving the mental health of Australians include the National Suicide Prevention Strategy: Living is for Everyone (LIFE) and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.⁽¹⁴⁾ The WA Suicide Prevention Strategy⁽⁹⁾ is aligned with the national strategy and One Life is a Western Australian initiative to strengthen families, communities and workplaces, and build resilience to prevent suicide.⁽¹⁵⁾

Suicide awareness and suicide bereavement for suicide survivors (postvention) are considered important forms of treatment and follow-up care but are not likely, on their own, to be sufficient to prevent suicide at either community or population levels.⁽¹⁶⁾

Restricting access to the means of suicide (prescription pharmaceuticals and other drugs, sharp objects or firearms) is another key element of suicide prevention efforts.⁽⁷⁾

Focus area	Target	Programs, campaigns and resources
Awareness and support	Community-wide men, women, young people, older people, Aboriginal people, LGBTI people, CaLD people, families Community development	Mental Health Commission WA directory of Online mental health support beyondblue beyondblue Black Dog Institute Black Dog Headspace Headspace Youth Focus Youth focus Injury Control Council of WA Understanding and Building Resilience Project

Focus area	Target	Programs, campaigns and resources
Training	Health professionals, families, organisations	Mental Health First Aid beyondblue Black Dog Institute KidsMatter National LGBTI Health Alliance MindOUT! project
Crisis and counselling	Community-wide men, women, young people, older people, Aboriginal people, LGBTI people, CaLD people, families	Mental Health Commission Mental health emergency response line RuralLink Lifeline Lifeline Mental Health Commission WA directory of Helplines Department of Child Protection and Family Support Crisis Care
Mental health services	Metropolitan regional child and adolescent community-wide Aboriginal	Department of Health Mental health services: metro Department of Health Mental health services: country Department of Health Mental health services: child and adolescent WAAMH and WANADA directory mental health and substances use services Green book Mental Health Commission Statewide Specialist Aboriginal Mental Health Service

5.5 Legislation, Standards and Codes of Practice

<p>Mental Health Act 1996 WA Legislation</p>	<p>Legislation to provide for the care, treatment, and protection of persons who have mental illness.</p> <p>The Mental Health Bill 2013 was introduced into the Legislative Assembly on 23 October 2013. If passed by Parliament it will replace the current Mental Health Act 1996. Mental Health Bill 2013</p>
<p>Firearms Act 1973 WA legislation</p> <p>Firearms Regulations 1974 WA regulations</p>	<p>Anyone wishing to possess or use a firearm must have a Firearm Licence and is required to demonstrate a genuine reason to own a firearm.</p> <p>Secure storage requirements for firearms are set out in the Firearm Regulations 1974.</p>
<p>Poisons Act 1964 WA Legislation</p> <p>Therapeutic Goods Act 1989 Australian legislation</p> <p>Child-Resistant Packaging Mandatory Australian standards</p>	<p>Regulates and controls the possession, sale and use of poisons and other substances.</p> <p>Requirements for inclusion in the Australian Register of Therapeutic Goods, including advertising, labelling, product appearance and appeal guidelines.</p> <p>Australian Standard AS 1928–2007 Child-resistant packaging- Requirements and testing procedures for reclosable packages (ISO 8317:2003, MOD)</p> <p>AS 2216 – 2001 Child-resistant packages (non-reclosable packages)</p>

Sources:

- WA State Law Publisher www.slp.wa.gov.au
- Standards Australia www.standards.org.au
- Commonwealth Law Publisher www.comlaw.gov.au

5.6 Conclusion

The age-standardised suicide rates in Australia have not changed between 2003 and 2012.⁽³⁾ Rates of intentional self-harm increased in Australia on average by 0.5 per cent per year from 105 cases per 100,000 population in 1999–00 to 117 in 2010–11.⁽¹⁷⁾

Pathways to suicide are often complex and multi-faceted⁽¹⁸⁾ and so strategies for prevention involve a wide range of approaches⁽¹⁹⁾. The WA Suicide Prevention Strategy recognises that suicide prevention is a shared responsibility and prevention activities should involve: the whole community; communities and groups that are most at risk of suicide; and individuals at risk of suicide.⁽⁹⁾

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6. Interpersonal Violence

Definition:

Interpersonal violence is defined by the World Health Organization (WHO) as ‘the intentional use of physical force, or power, threatened or actual, against oneself, another person, or against a group or community, that either results in, or has a likelihood of resulting in injury, death, psychological harm, mal-development or deprivation’.⁽¹⁾ Psychological harms include substance abuse, depression, suicide, anxiety, eating disorders and chronic pain.⁽²⁾

In WA, the term ‘domestic violence’ usually refers to abuse against an intimate partner, while family violence is a broader expression encompassing domestic violence and the abuse of children, the elderly and other family members. Aboriginal people generally prefer to use the term ‘family violence’. Family and domestic violence is considered to be behaviour which results in physical, sexual and/or psychological damage, forced social isolation, economic deprivation, or behaviour which causes the victim to live in fear.⁽³⁾

This report will not cover community violence, defined as ‘violence between people or groups who may or may not be known to each other (strangers or acquaintances), which occurs generally (but not always) in a public place’.⁽⁴⁾

6.1 Overview

In Australia patterns of interpersonal violence experienced by children, adolescents, women and men are different and may involve intimate partner violence, sexual violence, child maltreatment, youth violence and elder abuse.⁽⁵⁾ Alcohol and drug use are deeply entwined with violence in the Australian community.⁽²⁾

Domestic and sexual violence is overwhelmingly committed by men against women. Physical violence is a more common experience for men, most commonly committed by men.⁽⁵⁾⁽⁶⁾

Children’s exposure to domestic violence may be one feature of families in which other types of violence are also present.⁽⁷⁾

6.2 Risk and Protective Factors

6.2.1 Environmental factors

The rate of hospitalisation due to interpersonal violence in outer regional and remote areas of WA is significantly higher compared with the rate for people who live in metropolitan areas. This reflects the high rates of hospitalisation for interpersonal violence among Aboriginal people who comprise a larger proportion of the population in regional and remote areas.⁽⁸⁾

Individual factors

Gender

Amongst victims of violence, men are more likely to experience physical violence, while women are more likely to experience sexual violence. More than 60,000 women (7%) in WA will experience violence in a year, as will 77,000 (9%) of men.⁽⁵⁾ Over three times as many people experience violence from a male perpetrator rather than from a female.⁽⁶⁾ Males are twice as likely to die (an average of 13 deaths each year) and twice as likely to be hospitalised in WA from interpersonal violence as females.⁽⁸⁾

Age and development

In WA, police attend almost 24,000 family and domestic related incidents each year, of which half have a child or young person aged 0 to 17 years present, and 1,700 of these children and young people have injuries as a result of the incident. Mal-treatment of children and young people (physical abuse, sexual abuse, emotional abuse or neglect) is a significant issue in WA with almost 14,000 notifications of abuse or neglect received in a year.⁽⁹⁾

Young people in WA aged 18–24 years, both men and women, experience the highest rates of violence of any age group.⁽⁵⁾ The highest rates of interpersonal violence death are among men aged 35–39.⁽⁸⁾ An estimated 12,500 elderly people in WA will experience some form of elder abuse in a year.⁽¹⁰⁾

Ethnicity

Rates of death and hospitalisation due to interpersonal violence are much higher among Aboriginal people compared with non-Aboriginal people, with females 68 times more likely to be hospitalised and males 13 times more likely to be hospitalised.⁽⁸⁾ Aboriginal children and young people are significantly over-represented in family and domestic violence incidents as well as reports of child abuse and neglect.⁽⁹⁾ The over-representation of Aboriginal people in interpersonal violence has been linked to the impacts of colonisation, including inter-generational trauma, dispossession of land, forced removal of children, interrupted cultural practices that mitigate against interpersonal violence, and economic exclusion. The intersection of gender and racial inequality creates conditions for extremely high rates of violence against Aboriginal women.⁽¹¹⁾

Migrant and refugee women may have experienced rape, sexual assault, war, civil unrest and other types of conflicts in their lifetime journeys, including during time spent in refugee or detention camps. A convergence of factors once in Australia increases the risk of physical and sexual violence for women from CaLD backgrounds, including a lack of support networks, socio-economic disadvantage, community pressure and lack of knowledge about their rights.⁽¹²⁾

Disability

People with disabilities can have increased vulnerability to physical and sexual violence as a consequence of increased dependence on others.⁽¹³⁾ Reports of violence by women with disabilities are similar to those experienced by women without disabilities.⁽⁵⁾ However, women with disabilities experience specific forms of violence that are often invisible to others as well as experiencing the violence and abuse that is common to all women. This may lead to an underestimation of the actual levels of violence.⁽¹³⁾

6.2.3 Socioeconomic characteristics

Residents of the most disadvantaged areas in WA are six times more likely to be hospitalised from interpersonal violence than people who live in the least disadvantaged areas.⁽⁸⁾ Men with a degree/diploma or higher qualification are half as likely to experience physical threats as men with other levels of education. Unemployed men experience harassment at nearly 2.5 times the rate of employed men and more than four times the rate of men not in the labour force.⁽¹⁴⁾

6.2.4 Health behaviours

In WA two thirds of people who are victims of physical assault identify alcohol or other drugs as contributing to the violence. Alcohol contributes to 44 per cent of deaths due to interpersonal violence and is involved in 38 per cent of assaults, and 47 per cent of domestic assaults.⁽¹⁵⁾

6.3 Key Stakeholders in WA

State Government

Department of Health [Sexual Assault Resource Centre](#)

Department for Child Protection and Family Support [Child Protection Family and Domestic Violence](#)

Department of Local Government and Communities [Communities in Focus](#)

WA Police [Strategies on Family and Domestic Violence, Crime Prevention](#)

Department of Health WA Country Health Service [Population Health Units](#)

Other

Women’s Council for Domestic and Family Violence Services [WCDFVS](#)

Men’s Advisory Network [MAN](#)

[Relationships Australia](#)

Injury Control Council WA [ICCWA](#)

Research

Australian Institute of Criminology [AIC](#)

Australia’s National Research Organisation for Women’s Safety [ANROWS](#)

Australian Centre for the Study of Sexual Assault [ACSSA](#)

University of WA [Crime Research Centre](#)

6.4 Current Activities in WA

Reducing interpersonal violence forms part of the WA Health Promotion Strategic Framework to promote and support a safer community in WA.⁽¹⁶⁾ Western Australia’s Family and Domestic Violence Prevention Strategy to 2022⁽³⁾ is aligned with the National Plan to Reduce Violence against Women and their Children 2010–2022 that aims to achieve a significant and sustained reduction in violence against women and their children.⁽¹⁷⁾ Also linked to this is the WA Police Family and Domestic Violence Strategy.⁽¹⁸⁾ Protecting Children is Everyone’s Business, is the National Framework for Protecting Australia’s Children 2009–2020.⁽¹⁹⁾

Focus area	Target	Programs, campaigns and resources
Supportive environments for children and young people	Parents families and children	Department for Child Protection and Family Support Best beginnings 0–2 yrs Parent support 0–18 yrs Protecting children Department of Local Government and Communities Parenting and children Early years networks Middle years 9–14 Fly in Fly out Protective Behaviours WA Preventing child abuse Meerlinga Children and parenting Relationships Australia WA Parenting Fly in Fly out
	Aboriginal parents	Department of Health CACH Aboriginal health team Anglicare WA Aboriginal Early Years Meerlinga Aboriginal Parent Support Service Ngala For dads
	Fathers	The Fathering Project Helping men be better dads

Focus area	Target	Programs, campaigns and resources
Family support	Families with complex problems Families experiencing violence	Department for Child Protection and Family Support Strong Families Anglicare WA Family separation services Lifeline Separated dads WA Women's Council for Domestic and Family Violence Services Domestic Violence Outreach Safe at home angelhands Prevention and Safety Security HOPE Helping Others Overcome PTSD
Respectful relationships	Students Young people Intimate partners Aboriginal men Male DFV perpetrators Workplaces	Women's Council Promoting respect project White Ribbon Breaking the silence program Youth Focus Respectful relationships Relationships Australia WA Committed relationships Anger and conflict Men's Advisory Network The Mooditj Marmun Book Department for Child Protection and Family Support Freedom from fear resources Worksafe Aggression Bullying White Ribbon Workplace Program
Safety for elderly people	Older adults Families CaLD Aboriginal Residential facilities	Advocare Help with elder abuse Education CaLD resources Support for families with a relative entering residential care Assistance for older Aboriginal people Education Help with aged care complaints



Injury Prevention in WA: A Review of Statewide Activity of Selected Injury Areas

Focus area	Target	Programs, campaigns and resources
Emergency, crisis support	Domestic and family violence DFV DFV CaLD DFV same sex Sexual assault Child abuse Parenting Elder abuse	WA Police Domestic and family violence Department for Child Protection and Family Support access to helplines for Women’s domestic violence Men’s domestic violence Women’s Council Women’s refugees Women’s Law Centre Legal information Women’s Health and Family Services Multicultural Women’s Advocacy Service Same Sex Domestic Abuse Group SSDAG WA Police Sexual assault Department of Health Sexual Assault Resource Centre Department for Child Protection and Family Support District offices and Crisis Support Department for Child Protection and Family Support Family helpline Department of Local Government & Communities Parenting WA Alliance for the Prevention of Elder Abuse Hotline
Advocacy	Prevention of Domestic and Family Violence Elder abuse Community violence	White Ribbon Foundation Australia’s campaign to stop violence against women Women’s Council HURT Women’s Law Centre Law reform Alliance for the Prevention of Elder Abuse WA IF Foundation (formerly Luke Adams Foundation)

6.5 Legislation, Standards and Codes of Practice

<p>Criminal offences under the Criminal Code Act Compilation Act 1913 (particularly in relation to Part V—Offences against the person and relating to parental rights and duties and against the reputation of individuals) WA legislation</p> <p>Restraining Orders Act 1997 WA Legislation</p>	<p>Family and domestic violence</p> <p>Examples of criminal offences that occur in family and domestic violence situations include assault, sexual assault, making threats about a person’s physical safety, stalking, damage or stealing of property and breaching Restraining Orders.</p> <p>Police Orders, Violence Restraining Orders and Misconduct Restraining Orders are intended to protect people at risk of family and domestic violence.</p> <p>Sexual assault</p> <p>Sexual assault describes a broad range of sexual crimes committed against a person including sexual intercourse without consent and indecent assault.</p>
<p>Children and Community Services Act 2004 WA Legislation</p>	<p>Failing to protect child from harm is identified as a crime under Division 7</p>

Source:

- WA State Law Publisher www.slp.wa.gov.au

6.6 Conclusion

Violence is a complex problem and like other public health problems is predictable and preventable.⁽¹⁾

A commitment has been made in Western Australia to reduce the incidence of family and domestic violence through a focus on an integrated long-term response by state and Commonwealth governments, community sector organisations and the wider community.⁽³⁾

Responses should include targeted and appropriate violence prevention activities for high risk groups such as Aboriginal people, women, children, and young men, as well as community-wide initiatives.⁽²⁾

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7. Poisoning in Children

Definition:

Poisoning is when cells are injured or destroyed by the inhalation, ingestion, injection or absorption of a toxic substance. Poisoning patterns change according to age, type of exposure and the nature and dose of the poison.⁽¹⁾

Chronic poisoning issues related to lead, indoor air pollution or repeated or prolonged exposure to other toxic agents, allergic reactions to food or poisoning stemming from infectious agents are not covered in this discussion.

7.1 Overview

Thousands of infants and children who swallow, breathe or absorb toxic substances are treated at hospital emergency departments, by GPs or at home on advice from the WA Poisons Information Centre.⁽²⁾ In WA infants and toddlers have the highest risk of being hospitalised as a result of poisoning, but very few of these injuries among 0–4 year olds lead to death.⁽³⁾

Poisoning usually happens in the home,⁽³⁾ mostly by ingestion, and in the majority of cases children swallow a product used by someone else in the household in the previous 24 hours.⁽⁴⁾

The most common agents involved in childhood poisoning are:⁽¹⁾⁽²⁾

Pharmaceuticals:

- over-the-counter preparations such as paracetamol, cough/cold remedies, vitamins and iron tablets, antihistamines and anti-inflammatory drugs;
- prescription medications such as antidepressants; analgesics
- cigarettes, alcohol and illicit drugs.

Household products:

- bleach, disinfectants, detergents, cleaning agents, insecticide and cosmetics.

7.2 Risk and Protective Factors

7.2.1 Environmental factors

The most obvious risk factor for ingestion of a substance is its presence in the home environment, within reach of the child. Risks of poisoning among young children are reduced by storage in cupboards out of reach, use of locks on cupboards or cabinets and the use of child restraints – note: these are not child proof – for example, packages for medicines and substances.⁽¹⁾

7.2.2 Individual factors

Gender

There is little difference in the rates of poisoning by pharmaceuticals and other substances between Australian girls and boys aged 0–14 years but the rate is much higher among girls in the 15–17 years age group compared with boys.⁽⁵⁾

Age and Development

Infants and small children, 0–2 year olds, are closer to the ground than older children and tend to put their hands and small objects into their mouths. Children over two years old become more mobile and increase their abilities to reach, grasp and manipulate and are more likely than younger children to ingest pharmaceuticals.⁽⁶⁾ Rates of hospitalisation from poisoning in WA are highest for children 0–4 years. Rates fall steeply among 5–14 year olds and rise again among teenagers largely to the unintentional ingestion of pharmaceuticals by adolescents 15–17 years.⁽¹²⁾⁽⁵⁾

Ethnicity

The rates of poisoning by pharmaceuticals and other substances for Aboriginal children aged 0–4 are much higher than for non-Aboriginal Australians.⁽⁵⁾

7.2.3 Socioeconomic characteristics

Parents in lower socioeconomic groups may be aware of safety practices, however may face additional barriers to implementing these practices, due to extrinsic causal factors such as living in public housing, rental properties, or in the home of grandparents.⁽⁸⁾

7.2.4 Health beliefs and behaviours

Products such as garden chemicals that parents perceive as dangerous are more likely to be locked up out of the reach of children than over-the-counter medicines that are not thought of as dangerous.⁽⁴⁾

Parents and caregivers may rely on child-restraint packaging that is designed to delay access to poisonous substances but is not a guarantee to block access by children.⁽⁹⁾ Children commonly access products if they are not placed in safe storage immediately after purchase or after use and this can also be attributed to reliance on child-restraint packaging.⁽⁶⁾

7.3 Key Stakeholders in WA

State Government

Department of Health WA [Poisons Information Centre](#)

Department of Health [Injury Prevention](#)

Department of Health [Public and Population Health Units](#)

Department of Health WA Country Health Service [Population Health Units](#)

Other

[Kidsafe WA](#)

Injury Control Council of Western Australia [Injury fact sheets](#)

Research

Department of Health [WA Poisons Information Centre](#)

Monash University Accident Research Centre [Home, sport and leisure safety](#)

7.4 Current Activities in WA

Activities to prevent poisoning in children focus on programs, education and campaigns to promote and support a safer community in WA⁽¹⁰⁾ with interventions that target environmental factors and the behaviour of caregivers.⁽⁴⁾

Focus area	Target	Programs, campaigns and resources\
Home safety Locks, latches, barriers	Families with young children	Kidsafe WA Online safety demonstration house Home safety Poisons. Lock up and away Spring clean for poisons safety Fact sheets: Poisoning Poisonous plants WA Poisons Information Centre: Poisons in the home Bites and stings Harmful garden plants in WA
Home safety	CaLD families	Kidsafe WA Home safety fact sheets (translated) CaLD translated DVD and Facilitators Guide (available upon request)
Safe disposal medicines	Health professionals	Kidsafe WA Home safety community action kit Antenatal education resource kit
	Primary school students	Kidsafe WA Safety Island online
	Community	Return Unwanted Medicines RUM Project

7.5 Legislation, Standards and Codes of Practice

Poisons Act 1964 WA Legislation	Regulates and controls the possession, sale and use of poisons and other substances.
Therapeutic Goods Act 1989 Australian legislation	Requirements for inclusion in the Australian Register of Therapeutic Goods, including advertising, labelling, product appearance and appeal guidelines.
Child-Resistant Packaging Mandatory Australian standards	Australian Standard AS 1928–2007 Child-resistant packaging- Requirements and testing procedures for reclosable packages (ISO 8317:2003, MOD)
Requirements for Medicines Therapeutic Goods Order No. 80	AS 2216 – 2001 Child-resistant packages (non-reclosable packages)
Safe housing design Mandatory Australian standards	Australian standard AS 4226–2008 aspects relevant to prevention of poisoning include installation of lockable cabinets in bathrooms, laundry and kitchen.

Sources:

- WA State Law Publisher www.slp.wa.gov.au
- Standards Australia www.standards.org.au
- Commonwealth Law Publisher www.comlaw.gov.au

7.6 Conclusion

Poisoning among young children commonly occurs in everyday situations such as tablets left on the bench as a reminder for an adult to take the medication, pills carried in bags that children explore, and household products stored in cupboards within reach of children.⁽¹¹⁾

Initiatives in WA that are recommended as effective in preventing poisoning in children include; requirements for child-resistant packaging; promotion of safe storage at all times of medications and household products; and access to support from the WA Poisons Information Centre.⁽¹⁾

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11. Kidsafe WA. Poisoning fact sheet. <http://www.kidsafewa.com.au/factsheets.htm>
12. Health Tracks Reporting. Epidemiology Branch, WA Department of Health. Perth: Department of Health, Western Australia; 2015

8. Burns and Scalds

Definition:

A burn is an injury to the skin or other organic tissue primarily caused by heat or due to radiation, radioactivity, electricity, friction or contact with chemicals. Thermal (heat) burns occur when some or all of the cells in the skin or other tissues are destroyed by hot liquids (scalds); hot solids (contact burns), or flames (flame burns).⁽¹⁾

8.1 Overview

People at higher risk of burn and scald injuries in WA are young children, men aged 15–29 years, Aboriginal people and older adults.⁽²⁾ More than any other group, infants, toddlers and young children (ages 0–4 years) depend on others for the prevention of burns and scalds.⁽³⁾

The most common cause of death from burns is from fire in a building which caused 36 of the 91 deaths in WA between 2002 and 2011. Burn and scald injuries resulting in hospitalisation between 2004 and 2013 in WA were most commonly caused by hot fluids, and exposure to ignition of highly flammable materials. Other causes included exposure to controlled fire (not in building or structure); and exposure to smoke, fire and flames. Individuals and families are affected by relatively long stays in hospital for people with injuries from burns and scalds.⁽¹⁰⁾

8.2 Risk and Protective Factors

8.2.1 Environmental factors

More than half of injuries from burns and scalds happen in the home and are particularly associated with cooking and hot drinks, as well as household appliances such as stoves, heaters and fireplaces. Outside the home, burns also occur in workplaces and schools.⁽⁴⁾ Where people live in WA has a strong influence on being hospitalised for injuries from burns and scalds with the highest rates occurring in remote WA, followed by regional WA and the lowest rates in the major cities.⁽²⁾

8.2.2 Individual factors

Gender

Men are nearly three times as likely to die and twice as likely to be hospitalised from burn and scald injuries as women in WA.⁽¹⁰⁾ High rates of hospitalisation among young men aged 15–29 years,⁽¹⁰⁾ most commonly a burn injury from ignition of flammable material, may be associated with factors such as increased risk-taking behaviours, occupational hazards and societal gender roles.⁽⁵⁾

Age and Development

Children four years and under have by far the highest rates of hospitalisation for burns and scalds in WA, with scald injuries the most common cause, often related to hot drinks.⁽¹⁰⁾ There is some evidence of declining injuries from scalds following legislation in 1994 to reduce the temperature of hot water to <50°C in new homes. Further effects may be identified over time with modifications to existing homes.⁽⁴⁾

Among people aged 65 years and over, common injuries are flame burns (such as from fireplaces and stoves), scalds and contact burns. The highest rates of death for burns and scalds are among older adults⁽²⁾ and may be due to their relative frailty and higher occurrence of co-morbidities compared with younger people.⁽⁵⁾

Ethnicity

For Aboriginal people in WA the rates of hospitalisation due to burns and scalds are five times higher than non-Aboriginal people and these rates are consistent compared with declines in the rates among non-Aboriginal people in WA.⁽²⁾

8.2.3 Socioeconomic characteristics

Residents of the most disadvantaged areas in WA are 3.6 times more likely to be hospitalised for burn and scald injuries⁽²⁾ which may be due to the influence of factors such as low income, unemployment, illiteracy, and crowded living conditions.⁽⁶⁾

8.2.4 Health behaviours

Smoking, consuming alcohol and using drugs are associated with higher rates of burn injuries. The impact of regulations requiring all cigarettes sold in Australia since September 2010 to be reduced fire risk cigarettes has not yet been assessed.⁽⁷⁾

8.3 Key stakeholders in WA

State Government:

Department of Health [Injury Prevention](#)

Department of Health [Public and Population Health Units](#)

Department of Health WA Country Health Service [Population Health Units](#)

Department of Fire and Emergency Services [Safety Information: Fire](#)

Department of Commerce [Consumer Protection smoke alarms](#)

Department of Commerce [Worksafe safety and health topics](#)

Department of Housing [Tenant fact sheets](#)

Department of Parks and Wildlife [Fire management](#)

Other

[Kidsafe WA](#)

Western Power [Safety at home](#)

Injury Control Council of Western Australia (ICCWA) [Injury fact sheets](#)

ICCWA [Partnership & Sector Development Program](#)

Burns care and research

Department of Health Injury and Trauma Health Network

Perth Children's Hospital (from 2015) Princess Margaret Hospital

Royal Perth Hospital Burns Service

UWA School of Surgery Burn Injury Research Unit

8.4 Current Activities in WA

Activities for burn and scalds prevention focus on programs, education and campaigns to promote and support a safer community in WA.⁽⁸⁾ The Burn Injury Model of Care developed by the Injury & Trauma Health Network is a framework for collaboration between stakeholders.⁽⁹⁾

Focus area	Target	Programs, campaigns and resources
Smoke alarms	Community-wide	Department of Fire and Emergency Services Don't be a fool! Change your smoke alarm batteries on April 1. Only working smoke alarms save lives
	Tenants in public housing	Department of Housing Smoke alarm fact sheet and Testing safety devices fact sheet
Home safety	Community seniors, CaLD Aboriginal people	Department Fire and Emergency Services Home fire safety Home fire safety resources
Home safety resources: online print workshops	Families with young children	Kidsafe WA Home safety Online safety demonstration house Fires and burns fact sheet Winter safety: Get warm not burnt Child safety workshops
	CaLD families	Home safety fact sheets (translated) Kidsafe WA CaLD DVD & Facilitators Guide (available upon request)
Classroom resources excursions	School students and teachers	Department of Fire and Emergency Services Home fire safety Natural hazards Kidsafe WA School Presentations (grades 1–3)
Support program	Young people aged 6–16 who have been involved in fire lighting	Department of Fire and Emergency Services Juvenile and Family Fire Awareness Program
Child safety resources	Health professionals	Kidsafe WA Home safety community action kit Antenatal education resource kit
Resources for trade, industrial, offices	Workplaces	Worksafe Hazardous substances
Bushfires	Community	Department of Fire and Emergency Services Bushfire safety

8.5 Legislation, Standards and Codes of Practice

Smoke alarms WA Legislation	Smoke alarm requirements for new properties and existing homes.
Electrical safety switches	Australian standards AS/NZS 61008.1:2011 circuit breakers
Water temperature	AS/NZS 3500.4:2003/Amdt 2:2010 includes storage and delivery temperature standards
Hot water systems	AS/NZS 3500.4:2003/Amdt 2:2010 water supply
Safe housing design Mandatory Australian standards	AS 4226–2008 includes aspects of fire prevention (including heating, stoves and cooktops), fire escape, fire detection, fire fighting and hot water.
Cigarettes Mandatory Australian standard	The way a reduced fire risk cigarette is made slows down the rate at which the cigarette burns and is likely to self extinguish if the smoker does not draw on it.
Cigarette lighters Mandatory Australian standard	Requirements for child-resistant features
Fireworks WA Legislation	Public access to fireworks and use in Western Australia is banned. Fireworks events run by licensed operators are regulated.
Children’s clothing Mandatory Australian standard	Safety and labelling requirements for children’s nightwear.

Sources:

- WA Department of Fire and Emergency Services www.dfes.wa.gov.au
- Safety information/Fire in the home
- Standards Australia www.standards.org.au
- Product Safety Australia www.productsafety.gov.au
- Product categories/fire and flammables/candles with lead wicks; chemistry sets; cigarettes; cigarette lighters; combustible candle holders; nightwear for children; skylanterns

8.6 Conclusion

Strategies based on legislation and standards, product modification and education are being implemented in WA as this combination of approaches is identified as being the most effective in reducing the incidence of burns.⁽⁶⁾

Laws in Western Australia and Australian mandatory standards for smoke alarms, reduced fire risk cigarettes, controls on water temperatures and material in children’s clothing are in place and enforced.⁽³⁾

A reduction in the overall rate of hospitalisation in WA between 2008–2012 for burns and scalds is a positive trend. However, it is of concern that during this period the rates among Aboriginal people did not change and rates for Aboriginal females increased.⁽¹⁰⁾ Continuing efforts are needed to reduce the risks of burn and scald injuries among Aboriginal people, young children, young men, and older adults in WA.

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9. Drowning

Definition:

Drowning is the process of experiencing respiratory impairment from submersion and/or immersion in liquid and encompasses cases that result in either death, a level of morbidity, or no morbidity.⁽¹⁾

9.1 Overview

For many Western Australians, recreational activities are centred on or around beaches, rivers, lakes and pools and these, as well as daily activities around the home, can be associated with unintentional fatal and non-fatal drowning incidents.⁽²⁾

Between 2008 and 2012 in WA an average of 27 people died each year due to unintentional drowning and 108 people were hospitalised following a non-fatal drowning incident. Fatal and non-fatal drowning can occur at any time of year, however summer is the most common time of year followed by spring and autumn.⁽²⁾

9.2 Risk and Protective Factors

9.2.1 Environmental factors

Coastal locations (ocean and beach), home swimming pools, and rivers, lakes and dams are the most common sites for fatal and non-fatal drowning in WA.⁽²⁾ The rate of death in remote/very remote areas is three times higher compared with deaths from drowning and hospitalisation for non-fatal drowning in major WA cities.⁽³⁾

Fencing which completely encloses all sides of a swimming pool and isolates it from the home is effective in preventing drowning of young children.⁽⁴⁾

9.2.2 Individual factors

Gender

Males are around four times as likely to drown and twice as likely to be hospitalised following an immersion incident as females in WA⁽³⁾ with research suggesting that this is due to males being more frequently involved in high risk situations around water.⁽⁵⁾

Age and Development

Swimming lessons and greater swimming ability offer some protection, even at relatively young ages, but do not result in 'drown proofing' of children.⁽⁶⁾⁽⁷⁾ A momentary lapse by adults in one or more of the three aspects of supervision: attention (watching and listening); proximity (touching or being within reach) and how continuous (constant, intermittent or not at all) is generally associated with drowning, rather than the complete lack of supervision.⁽¹⁾

Ethnicity and residency

The rate of drowning among Aboriginal people is more than four times greater than non-Aboriginal people in WA.⁽³⁾ International tourists and interstate visitors are at higher risk of drowning, as are residents of WA who are from culturally and linguistically diverse (CaLD) backgrounds.⁽²⁾

Underlying medical conditions

Medical conditions such as heart disease, high blood pressure, epilepsy and cerebral palsy may contribute to deaths from drowning.⁽⁸⁾

9.2.3 Socioeconomic characteristics

Residents of the most disadvantaged areas in WA are almost four times more likely to drown than people who live in the least disadvantaged areas.⁽³⁾ International research suggests that differences in swimming ability and experience in the water, lack of opportunities to learn to swim, and lack of supervision in high-risk environments may contribute to this difference.⁽¹⁾

9.2.4 Health behaviours

Among people, particularly males, alcohol has been identified as a factor in 20 per cent of deaths from drowning in Australia. Reports also show the presence of marijuana among some men who drowned.⁽⁹⁾

9.3 Key Stakeholders in WA

State Government

Department of Health [Injury Prevention](#)

Department of Transport [Marine Safety](#)

Department of Education [Interm swimming and Vacation Swimming](#)

Department of Fisheries [Community and schools education](#)

Department of Health [Public and Population Health Units](#)

Department of Health WA Country Health Service [Population Health Units](#)

Department of Health [Environmental Health Directorate, Water Unit](#)

Other

Royal Life Saving Society WA [Community](#)

Surf Life Saving WA [Community education](#)

Kidsafe [Home safety](#)

Recfishwa [Fishing safety](#)

Local Government Authorities

Australian Water Safety Council [Towards a nation free from drowning](#)

Injury Control Council WA [Partnership & Sector Development Program](#)

9.4 Current Activities in WA

Key priority areas in the Australian Water Safety Strategy 2012–2015⁽⁹⁾ are:

- taking a life stages perspective
- targeting high risk locations
- focusing on key drowning challenges.

This is supported by the Western Australian Health Promotion Strategic Framework 2012–2016 for action to promote and support a safer community in WA.⁽¹⁰⁾

Injury Prevention in WA: A Review of Statewide Activity of Selected Injury Areas

Focus area	Target	Programs, campaigns and resources
Drowning prevention	Children under 5	Royal Life Saving Society WA Keep watch Water safety Kidsafe WA Stay safe this summer Home safety
Primary school swim lessons	Children aged 0–14	Department of Education Interm swimming and Vacation Swimming
School education beach safety		Surf Life Saving WA Surf babies, Surf kids, Surfs up, Become a Nipper BeachSAFE, Life skills for life, Beach activities
Water safety		Paraplegic Benefit Fund What are you diving into?
Floods, cyclone safety		Department of Fire and Emergency Services Natural hazards
Water safety	Community	Royal Life Saving Society WA Water safety
	Aboriginal	Royal Life Saving Society WA Remote Aboriginal swimming pools project including mums and bubs swimming lessons
	CaLD	Royal Life Saving Society WA Culturally and Linguistically Diverse
Alcohol and drugs	Community	Department of Transport (Marine Safety) Don't go overboard on alcohol
	Young men aged 15–29	Royal Life Saving Society WA Don't drink and drown
Surf and coastal safety	Community	Surf Life Saving WA, Local Government BeachSAFE Coastal Aquatic Safety Surf Life Saving Australia Beachsafe Royal Life Saving Society WA Water safety at the beach
	Young men aged 15–29	Paraplegic Benefit Fund Watch your back in the waves
	CaLD	Surf Life Saving Australia On the same wave Beachsafe multilingual
Surf schools	Community 5–12 years	Surfing WA Learn to surf Surf Groms
Surf rescue	Community	Surf Life Saving WA Surf rescue First aid Lifesavers and Lifeguards Lifesaver Rescue Helicopter Jet Ski Team
Coastal safety framework	Lifeguards government industry	Surf Life Saving Australia CoastSafe

Focus area	Target	Programs, campaigns and resources
Swimming pools	Home pools Public pools	Local Government Authorities compliance checks on safety features Royal Life Saving Society WA safe venues Watch around water Environmental Health Directorate, Department of Health Regulation of recreational pools, water parks
Boating Sailing Kayaking Diving Snorkelling Jet skiing Marine safety education Recreational fishing	Community School students Community Young people 10–17 years Community schools	Department of Transport (Marine Safety) Boating safety campaigns Recreational boating and water sport Royal Life Saving Society WA Water safety when boating Surf Life Saving WA Kite boarding – Be safe WA Kite Surfing Association Safety Marine Education Boatshed Recfishwest Fishing safety Rock fishing safety Royal Life Saving Society WA Water safety when fishing Recfishwest Fishing clinics metropolitan and regional Department of Fisheries Community and schools education
Rivers, lakes, dams	Community Children	Royal Life Saving Society WA Water safety at rivers and lakes Water safety at the farm Kidsafe WA farm



9.5 Legislation, Standards and Codes of Practice

Private swimming pools and spas	Australian standards AS 2818–1993 Guide to swimming pool safety AS 2610.2–2007/Amdt 1–2011: Private spas AS 1926.3–2010/Amdt 1–2011 Water recirculation systems (includes skimmer boxes)
Barriers for private swimming pools and spas Mandatory Australian standards	Pool safety barriers must comply with the provisions of the Building Code of Australia, Building Regulations 2012 & Australian Standards AS 1926.1–2012 Safety barriers for swimming pools AS 1926.2–2007/Amdt 2–2011 Location of safety barriers DR AS 2820 (Revision of AS 2820–1993) Gate units for private swimming pools
Maintenance and inspection of pool and spa barriers	Local Government Authorities approve installation and are required to inspect swimming pools and spas at least once every four years to ensure compliance of the barriers with the legislative requirements listed above.
Public aquatic facilities WA Regulations and Code of Practice	WA Health (Aquatic Facilities) Regulations 2007 incorporating the Code of Practice for the Design, Construction, Operation, Management and maintenance of Aquatic Facilities (2013)
Marine safety Mandatory Australian standards WA Certificate of competency	Australian standards AS 4758.1–2008 Personal flotation devices AS 1900–2002 Flotation aids for water familiarization and swimming tuition AS 2261–1990 Rescue buoys Recreational Skippers Ticket

Sources:

- Western Australian Consolidated Regulations, Building Regulations 2012 www.austlii.edu.au/au/legis/wa/consol_reg/br2012200/
- Standards Australia www.standards.org.au
- WA Department of Health www.public.health.wa.gov.au/2/641/2/aquatic_facilities.pm
- WA Department of Transport (Marine Safety) www.transport.wa.gov.au/imate/recreational-boating.asp

9.6 Conclusion

The Australian Water Safety Strategy is a multi-faceted approach to drowning prevention with key priority areas including taking a life stages perspective; targeting high risk locations; and focusing on key drowning challenges.⁽⁹⁾

In Western Australia, progress has been made in a number of key priority areas⁽²⁾ however, as the number of people who drown is still high, there is a need for further work to reduce drowning deaths:⁽⁹⁾

- among toddlers aged 0–4 years
- among people aged 55+ years

- occurring at inland waterways
- involving watercraft and recreational activities (particularly rock fishing)
- among high risk populations (particularly culturally and linguistically diverse groups).

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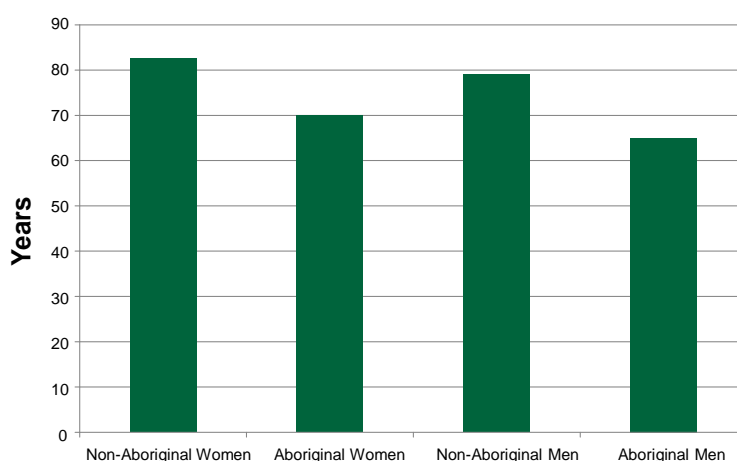
10. Aboriginal People and Injury Prevention

Aboriginal people live throughout WA including in the most remote areas of the state and make up 3.8 per cent of the Western Australian population.⁽¹⁾

10.1 Overview

There is disparity between Aboriginal and non-Aboriginal Australians with the burden of disease two and a half times higher among Aboriginal people. Life expectancy is significantly lower for Aboriginal people in Australia in comparison with non-Aboriginal people (Figure 1).⁽²⁾

Figure 1: Life Expectancy in Australia



Aboriginal people are over-represented in injury deaths and hospitalisations in WA. Compared with non-Aboriginal people, Aboriginal people have much higher rates (two to five times higher) for most types of injury including falls, drowning, burns, suicide, poisoning, and road crashes.⁽³⁾

The differences between Aboriginal and non-Aboriginal people for injuries due to interpersonal violence are also significant. An Aboriginal woman in WA is 67 times more likely to be hospitalised for an injury due to interpersonal violence compared with a non-Aboriginal woman, while Aboriginal men are 13 times more likely compared with non-Aboriginal men in WA.⁽³⁾

The gap may be even wider as events of interpersonal violence are generally under-reported, especially in Aboriginal populations.⁽⁴⁾

In Australia the leading causes of hospitalisation and deaths for injuries for Aboriginal children are the same as for non-Aboriginal children: falls, land transport accidents, assault, accidental poisoning, burns and scalds, and intentional self-harm – although the rates of each of these are consistently higher for Aboriginal children. In particular, the rate for hospitalisation due to assault for Aboriginal children is over five times higher than for non-Aboriginal children. The rates of death among Aboriginal children from poisoning; burns and scalds; and intentional self-harm are four to five times higher than the rates for non-Aboriginal children.⁽⁵⁾

10.2 Influences on Injury Among Aboriginal People

10.2.1 Historical and cultural context

Aboriginal concepts of health and illness differ from those in the non-Aboriginal population and impact upon the health outcomes and health service utilisation of Aboriginal people.⁽⁶⁾ Approaches to health should incorporate the significance of country, family and community to Aboriginal people, acknowledge the diversity of cultural practices across Aboriginal communities, and understand the historical relationships between Aboriginal people and governments that has discouraged health service utilisation in these groups.⁽⁷⁾

Factors influencing the disparity in health and injury status in Aboriginal communities include the social, environmental and historical circumstances that have occurred over generations. These and other factors have contributed to a range of contemporary social problems in some Aboriginal communities.⁽⁸⁾ These social determinants have contributed to poor health outcomes and higher rates of injury within Aboriginal populations.⁽⁹⁾

10.2.2 Living in rural and remote locations

For all Australians living in rural and remote locations, the rates of injury are higher than for people who live in regional and metropolitan areas.⁽¹⁰⁾

The increased rates of injuries from road transport in rural and remote locations are due to risk factors such as greater distances travelled, higher speed limits, poor road conditions, delays in reaching crash sites to treat people, risk of collision with livestock and wildlife, as well as reduced police enforcement of speed limits, laws on drink driving and seatbelt wearing. Long distance travel by Aboriginal families is common to attend funerals, to be with family and to return to country to support those who live there and to care for the land.⁽¹¹⁾

People in rural and remote locations also have lower exposure to injury prevention strategies for physical and mental health promotion, less access to support and counselling services, and fewer treatment and rehabilitation facilities. Among Aboriginal people there may be additional barriers relating to the cultural competence of health practitioners.⁽⁷⁾

10.2.3 Health behaviours

Vehicle passenger safety

There is a higher rate of death and serious injury among car passengers relative to car drivers among Aboriginal people compared with non-Aboriginal people⁽¹²⁾ and this is related to non-wearing of seatbelts or restraints (particularly by children), and overcrowding in vehicles.

Alcohol use

The use of alcohol is a contributing factor to one in five deaths from injury for Aboriginal and non-Aboriginal people in WA. For Aboriginal people the most common cause related to alcohol is land transport, followed by suicide and interpersonal violence. For non-Aboriginal people suicide is the most common cause followed by land transport. Hospitalisation rates for injuries that are alcohol-related are twice as high for Aboriginal people compared with non-Aboriginal people in WA with higher rates for interpersonal violence being the main contributor to the difference.⁽³⁾

10.3 Key Stakeholders in WA

State Government

Department of Health [Aboriginal Health Aboriginal Health Services](#)

Department of Health WA Country Health Service [Aboriginal Health](#)

Drug and Alcohol Office [DAO](#)

Department of Health WA Country Health Service [Population Health Units](#)

Department of Aboriginal Affairs [DAA](#)

Department of Health [Public Health and Clinical Services Division](#)

Other

The Aboriginal Health Council of Western Australia [AHCWA](#)

Aboriginal Health Services [WA regional and metropolitan](#)

The Aboriginal Alcohol and Drug Service [AADS](#)

South-West Aboriginal Land and Sea Council [Noongar people in SW WA](#)

Yamatji Marlpa Aboriginal Corporation [Pilbara, Murchison, Gascoyne](#)

Goldfields Land and Sea Council [Goldfields, Esperance](#)

Kimberley Land Council [Kimberley](#)

Ngaanyatjarra Council [communities in east of WA & Alice Springs](#)

Australian Indigenous HealthInfoNet [HealthInfoNet](#)

Injury Control Council of Western Australia [ICCWA](#)

Department of Infrastructure and Regional Development [Indigenous Road Safety](#)

National Congress of Australia's First People [Congress](#)

Reconciliation Australia [programs](#)

10.4 Current Activities in WA

The Commonwealth Government's National Aboriginal and Torres Strait Islander Health Plan (2013–2023) identifies that targeted, evidence-based action is needed to achieve equality of health status and life expectancy between Aboriginal people and non-Aboriginal Australians by 2031 – one of the six Closing the Gap targets. The Plan builds on the United Nations Declaration on the Rights of Indigenous Peoples.⁽¹³⁾

Participating with and engaging successfully with Aboriginal communities requires:⁽¹⁴⁾

- an appreciation of, and the cultural competency to respond to, Aboriginal history, cultures and contemporary social dynamics and to the diversity of Aboriginal communities; valuing the cultural skills and knowledge of community organisations and Aboriginal people
- clarity about the purpose and the relevant scale for engagement, which may call for multi-layered processes
- engagement that relates to Aboriginal concepts of wellbeing
- long-term relationships of trust, respect and honesty as well as accessible, ongoing communication and information
- effective governance and capacity within Aboriginal communities and organisations, government and other organisations involved
- appropriate time frames (including for deliberation and responsive funding, where applicable).

The WA Aboriginal Health and Wellbeing Framework 2015–2030 identified key guiding principles, strategic directions and priority areas for the coming years, to improve the health and wellbeing of Aboriginal people in WA. The Framework has a strong focus on prevention and

acknowledges culture as a key determinant of health. Guiding principles include:

- cultural security
- the health and wellbeing of Aboriginal people is everybody’s business
- partnership
- Aboriginal community control and engagement
- access and equality and
- accountability.

The Aboriginal Men’s Health Strategy 2012–2015 provides guidance for the WA Department of Health to work in partnership with non-government organisations and communities to improve the health of Aboriginal men.⁽¹⁵⁾

Strategies that focus on improving mental health are part of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.⁽¹⁶⁾ As part of the WA Mental Health 2020 Strategic Policy, a Statewide Specialist Aboriginal mental health service is working to provide a culturally responsive ‘whole of family’ approach for Aboriginal people in WA with a significant mental health problem and/or mental illness by:

- supporting Aboriginal people to access mainstream mental health services
- increasing the capacity of mainstream services to be more culturally responsive
- increasing mental health services in regional and remote areas and employing cultural brokers and
- fostering culturally responsive services throughout the state.

Focus area	Target	Programs, campaigns and resources
Health and wellbeing	Metropolitan Regional	Aboriginal Health Services metro and regional Mental Health Commission Statewide Specialist Aboriginal Mental Health Service Injury Control Council WA Healing through the map
	Women	Women’s Health and Family Services Aboriginal programs
	Men	MAN Mooditj Marmun Book
Community Development	Communities Enterprise ownership	Aboriginal Corporations and Resource Agencies in regional and metropolitan WA
Training and Employment	Jobseekers and employers	Department of Training and Workforce Development Aboriginal Workforce Development Centres Generation one promoting indigenous employment
Housing	Home Ownership	Department of Housing Keystart Aboriginal home loan
	Remote housing	Department of Housing Remote Aboriginal Housing

Focus area	Target	Programs, campaigns and resources
Alcohol and other drugs	Community attitudes Alcohol availability Support and counselling	Drug and Alcohol Office Strong Spirit Strong Mind Marninwarntikura Fitzroy Women’s Resource Centre Reclaiming hope Aboriginal Alcohol and Drug Service AADS Drug and Alcohol Office Help for Aboriginal people
Road safety	Road users Safe roads and roadsides	Office of Road Safety Indigenous road safety WALGA RoadWise Indigenous road safety Department of Infrastructure and Regional Development Being Safe, Not Sorry DVD WALGA RoadWise Road safety in your area: regions
Water safety	Education and training	Royal Life Saving Society WA Remote Aboriginal swimming pools project including mums and bubs swimming lessons Kidsafe WA Watch out for your kids – Indigenous resources
Prevention of Falls, Poisoning, Burns/Scalds	Children	Kidsafe WA Watch out for your kids – Indigenous resources

10.5 Conclusion

Higher rates of injury among Aboriginal children and adults contribute to the significant disparity in hospitalisations, deaths, and life expectancy when compared with non-Aboriginal people in WA.⁽²⁾⁽³⁾

Western Australian and national strategies for injury prevention among Aboriginal people adopt strengths-based approaches to ensure policies and programs improve health, social and emotional wellbeing, build resilience and promote positive health behaviours.⁽¹³⁾⁽¹⁷⁾

As well as initiatives to address social determinants of health such as employment, housing and to strengthen communities, continued action is needed by the injury prevention sector to focus on prevention of interpersonal violence, drowning, fires, poisoning, and road crashes among Aboriginal people in WA.

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11. Alcohol and Injury Prevention

Definition:

Alcohol-related injuries refer to both intentional (suicide and interpersonal violence) and unintentional (vehicle crashes, falls, drowning and burns) injuries that have been found to be attributable to the acute effects of alcohol.⁽¹⁾ The individual who is drinking and/or intoxicated may be injured, and/or their actions may result in injuries to family members, friends or strangers.⁽²⁾

The harms from alcohol are related to both the volume of alcohol consumed and patterns of drinking.⁽³⁾ The role of alcohol in injuries from road crashes, drowning, poisoning, falls, burns and scalds, suicide and interpersonal violence are covered in other chapters of this report.

11.1 Overview

Drinking alcohol is an activity for a majority of people in WA with 58 per cent of men and 44 per cent of women drinking on at least one day each week.⁽⁴⁾ In WA the harmful effects of alcohol contribute to 20 per cent of injury deaths and 12 per cent of hospitalisations from injury.⁽⁵⁾

There is no safe level of alcohol consumption and the more a person drinks, the greater the risk. For two standard drinks, the odds of an injury are almost double for most types of injury⁽⁶⁾ due to the influence of alcohol on aggression, reduction of fears about risky behaviours, impaired problem solving ability and other effects.⁽³⁾ Around one in five Western Australians aged over 18 years drinks at risk of an alcohol-related injury from a single occasion at least once a week and around one in 20 do so almost every day.⁽⁴⁾

Teenagers are developing mentally and physically and are more vulnerable to the effects of alcohol than adults. Although the rate of underage drinking is declining in WA, there are concerns that thousands of school students aged 12–17 who report drinking alcohol, have drinking patterns that are similar to those of adults. This places them at risk of short term harm and establishing patterns of drinking with lifetime risks of harm.⁽⁷⁾

11.2 Risk and Protective Factors

11.2.1 Environmental factors that influence alcohol consumption

Cultural norms

Most Western Australian adults (90%) have consumed a full serve of alcohol at least once in their lifetime.⁽⁴⁾ Between 2000 and 2012 in Australia there were changes in the type of alcohol chosen, but the total amount of alcohol consumed has remained much the same with WA adults drinking more than the national average.⁽³⁾

In 2011 a survey of 12–17 year old school students in WA found that almost one in four (24%) reported that they had never consumed alcohol. This is a significant increase from one in six students in 2008 (16%) and from one in 10 students in 1993 (10%).⁽⁷⁾ Despite the growing numbers of non-drinkers, teenagers and parents of teenagers still believe that almost all young people drink alcohol. Tackling this misconception is important as it affects attitudes of teenagers and their parents towards underage drinking and attitudes of parents towards supplying alcohol to teenagers.⁽⁸⁾

Among young people who drink alcohol, many display attitudes that reflect a culture of drinking to excess. Among WA school students aged 16 to 17 who reported drinking in the past week, approximately 40 per cent said ‘one of the main reasons I drink is to get drunk’, and ‘occasionally getting very drunk and losing control is good fun’.⁽⁷⁾

Price of alcohol

The cost of alcohol is an important factor in consumption and alcohol-related harm.

When alcohol is more expensive, people drink less and even small increases in the price of alcohol can have a significant impact.⁽⁹⁾ Young people are particularly responsive to the price of alcohol.⁽¹⁰⁾

Availability of alcohol

The sale of alcohol in WA is regulated through liquor licenses with more than 4,500 licensed premises in 2013.⁽¹¹⁾ Outlet density, days and opening hours are strongly related to alcohol consumption and harms, including assaults.⁽¹²⁾

Community-wide approaches such as the Kalgoorlie Alcohol Action Project have incorporated activities that seek to limit the number of alcohol outlets or prevent extended trading hours.⁽¹³⁾

Restrictions on alcohol in some rural WA locations include limits on trading hours for alcohol outlets, hours for takeaway sales, types of alcoholic drinks (e.g. full-strength beer) or packaging (e.g. less than two litre containers).⁽¹²⁾ ‘Dry’ community declarations have been made by remote Aboriginal communities through a combination of community control and state government authority. Although there are short-comings (e.g. sly grogging) and associated costs to this approach, overall outcomes for communities’ reductions in consumption and alcohol-related harms have been positive.⁽¹²⁾⁽¹⁴⁾

The 2013 WA Review of the Liquor Control Act 1988 recommended secondary supply laws that would make it an offence to supply alcohol to young people (under 18 years) on unlicensed premises.⁽¹¹⁾

Marketing of alcohol

An increase in alcohol consumption is linked to increases in the amount of promotion, estimated by money spent on advertising alcohol.⁽⁹⁾ Alcohol is marketed through paid advertising, promotions linking alcohol brands to sports and cultural activities, product placements, and new marketing techniques such as e-mails, SMS and podcasting, social media and other communication techniques. It is very difficult to target young adult consumers without exposing adolescents under the legal age to the same marketing.⁽¹⁰⁾

11.2.2 Individual factors

Gender

Alcohol makes a significant contribution to injuries among Western Australians with 28 per cent of injury deaths and 13 per cent of hospitalisations for injury among men related to alcohol use. For WA women alcohol use contributes to 12 per cent of deaths from injuries and 6 per cent of hospitalisations.⁽⁵⁾ The most common causes for women to be hospitalised from injury due to alcohol are falls, interpersonal violence and self-harm and for men they are interpersonal violence, falls and road crashes. Alcohol contributes to one in three deaths from suicide for both men and women in WA. One quarter of road crash deaths in WA are alcohol-related and alcohol contributes to more than eight times as many road crash deaths among men than women.⁽⁵⁾

Age and development

Adolescents and young adults (15–29 years) have high rates of alcohol-related death and injury.⁽⁵⁾ At least part of the excess risk among young people is related to the fact that, typically, a greater proportion of the total alcohol consumed by young people is consumed during heavy drinking episodes. Also, young people appear to be less risk-averse and may engage in more reckless behaviour while drunk.⁽¹⁵⁾

Rates of death and hospitalisation from alcohol-related injury also rise steadily in older adults (65 years and over).⁽⁵⁾

Ethnicity

Aboriginal people are more likely than non-Aboriginal people to abstain from alcohol. However, the prevalence of harmful alcohol use among Aboriginal people is about twice as great as that for non-Aboriginal people⁽¹⁶⁾ and interpersonal violence is more commonly a cause of alcohol-related injury among Aboriginal people compared with non-Aboriginal people in WA.⁽⁵⁾ Greater harm may be linked to social and structural determinants of health such as educational attainment, employment status, inclusion and exclusion.⁽¹⁶⁾

11.2.3 Socioeconomic characteristics

Risky alcohol consumption does not follow a clear socioeconomic gradient within Australia.⁽¹⁷⁾ However, groups with lower socioeconomic status are at a greater risk of injury, and alcohol use may contribute to an increased injury burden in these populations.⁽¹⁸⁾

11.3 Key Stakeholders in WA

State Government

Drug and Alcohol Office [DAO](#)

Department of Health [Injury Prevention](#)

Department of Health WA Country Health Service [Population Health Units](#)

Department of Education [School Drug Education & Road Aware \(SDERA\)](#)

Other

Western Australian Network of Alcohol and other Drug Agencies [WANADA](#)

McCusker Centre for Action on Alcohol and Youth [MCAAY](#)

Injury Control Council of Western Australia [ICCWA](#)

Public Health Advocacy Institute of WA [PHAIWA](#)

The Aboriginal Alcohol and Drug Service [AADS](#)

Department of Veterans Affairs [The Right Mix](#)

Local Drug Action Groups [LDAGs](#)

WA Alcohol & Youth Action Coalition [WAAYAC](#)

National Alliance for Action on Alcohol [NAAA](#)

Research

Curtin University, National Drug Research Institute [NDRI](#)

Foundation for Alcohol Research and Education [FARE](#)

11.4 Current Activities in WA

Efforts to reduce drinking both on a population level on and an individual level are important in reducing alcohol-related injury.⁽⁶⁾ Reducing harmful alcohol use to promote and support a safer community in WA forms part of the Western Australian Health Promotion Strategic Framework 2012–2016 and the Drug and Alcohol Interagency Strategic Framework 2011–2015, and align to the National Drug Strategy 2010–2015.⁽¹⁹⁾⁽²⁰⁾ For individuals, the National Health and Medical Research Council guidelines to reduce health risks from drinking alcohol, provide information for people to make decisions about their alcohol use.⁽²¹⁾

Key factors required for positive change from restrictions on the sale and supply of alcohol have been identified as:⁽¹²⁾

- effective enforcement
- community support
- control and awareness of restrictions
- consideration of substitution practices and displacement of drinkers
- meeting the specific and changing needs of the target population
- evidence-based initiatives that are suitable for each situation
- specific recommendations for regional, remote and Aboriginal communities.

Focus area	Target	Programs, campaigns and resources
Education, changes in community attitudes	Community-wide	Drug and Alcohol Office Alcohol think again Hello Sunday Morning HSM Dry July Healthway Sport arts community event sponsorship Local Drug Action Groups LDAG
	Aboriginal people	Drug and Alcohol Office Strong Spirit Strong Mind
	Children and young people	Royal Perth Hospital PARTY Program Department of Education School Drug Education
	Veterans	Department of Veterans Affairs The Right Mix
Advocacy for changes to alcohol environments	Alcohol price, availability, marketing	Drug and Alcohol Office A community approach McCusker Centre for Action on Alcohol and Youth MCAAY Injury Control Council WA & MCAAY Alcohol Action Station newsletter WA Alcohol & Youth Action Coalition WAAYAC Public Health Advocacy Institute WA Alcohol Western Australian Network of Alcohol and other Drug Agencies WANADA Advocacy National Alliance for Action on Alcohol NAAA Foundation for Alcohol Research Education FARE
	Entertainment venues and sporting clubs	Drug and Alcohol Office Night Venues and Entertainment Events Project Australian Drug Foundation Good sports Healthway Healthy clubs

Focus area	Target	Programs, campaigns and resources
Support and counselling	Community-wide	Department of Health Alcohol and Drug Information Service Community drug services
	Young people and parents	Drug and Alcohol Office Young people Parents and families
	Aboriginal people	Aboriginal Alcohol and Drug Service AADS
	CaLD people	Drug and Alcohol Office Help for non-English speakers

11.5 Legislation, Standards and Codes of Practice

WA legislation and regulations Liquor Control Act 1988 Regulations	The Liquor Control Act 1988 regulates the sale, supply and consumption of liquor, the use of premises on which liquor is sold and the services and facilities provided in conjunction with, or ancillary to the sale of liquor in order to minimise harm or ill-health caused to people due to the use of liquor.
2014 review of WA legislation Liquor Control Act 1988 – Review Report	Recommendations of the Review include changes to: Objects of the Act; Alcohol availability; Alcohol marketing; Community engagement and education.

Sources:

- WA State Law Publisher www.slp.wa.gov.au
- WA Department of Racing, Gaming and Liquor www.rgl.wa.gov.au

11.6 Conclusion

Large volumes of alcohol are consumed in Western Australia. The estimated per capita adult alcohol consumption in Western Australia in 2010 was more than 12 litres per person per year – higher than the Australian average of 10 litres. The amount of alcohol drunk by adults in Australia did not change significantly between 2000/01 and 2011/12.⁽³⁾

Alcohol-related harm is a whole-of-community problem. The WA government, Commonwealth and local governments, non-government organisations, communities, families and individuals have an active and ongoing role to address the harms caused by alcohol use in Western Australia.

There are a broad range of approaches to reduce alcohol-related injury that include community-wide strategies relating to the price, availability and marketing of alcohol, targeted programs that focus on specific settings or population groups, promotion of alternative activities not connected to alcohol, as well as encouragement for individuals to reduce their alcohol consumption.

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