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Identifying national priorities for injury prevention

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NISU has recently prepared a discussion paper to assist the Department of Health and Ageing (DHA) in identifying priority injury issues for the next *National Injury Prevention Plan*. The paper provides a contextual basis for considering topics and proposes and describes a set of topics as candidates for selection.

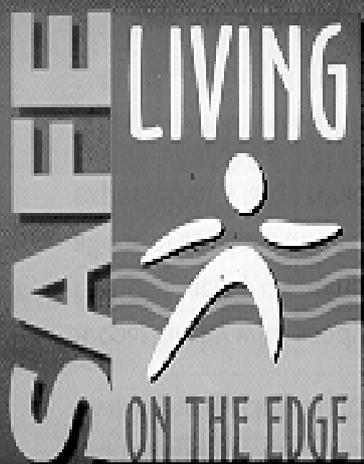
Criteria for assessment of potential topics

The selection of priority areas for the current document was undertaken under the direction and guidance of the Department of Health and Ageing and the Strategic Injury Prevention Partnership (SIPP). As with the first Plan, the selection of a limited number of topics was seen to maximise the potential for advancement in

a number of discrete areas. Such an approach is particularly important as limited economic resources can best be applied to greater effect over a smaller number of areas. The topics chosen were also selected with a view to avoiding duplication of resources. Other Commonwealth and jurisdictional portfolio areas are actively involved in injury prevention and intervention, particularly in the areas of occupation and transport injury.

In addition to the guidance received from DHA and SIPP, information gathered from a number of sources, including consultation with experts in the field and a review of past priority setting documents, narrowed the range of potential priority areas from which to

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7th Australian Injury Prevention Conference 2nd Pacific Rim Safe Communities Conference

15-17 SEPTEMBER 2004, MACKAY, QUEENSLAND

This conference will seek to:

- pool expertise across professional and national boundaries
- gain a richer understanding of what safety is and how it is achieved
- discover new insights into the meaning of risk and the means of controlling risk
- share interventions, research and policy that are cutting edge.

Identifying national priorities for injury prevention

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select. Using the population based approach, six thematic areas were chosen. A number of other areas could have been selected, such as a topic focusing on the population of women or culturally and linguistically diverse people. The merits of including or excluding these groups were considered. Their exclusion at this point in time is not a reflection of their degree of importance but is a consequence of the decision to limit the selection to six topics, in combination with assessment in terms of a set of criteria below.

The criteria were used in a limited way to guide the selection of the priority areas, more importantly they have provided a broader picture of the needs of each of the priority areas and within each area, variations in the importance of a number of criteria can be seen. Specifically, the chosen criteria were:

- Political and economic climate
- Lifetime of the Plan
- Future potential
- Momentum of existing topics
- Availability of interventions
- Frequency and severity of injury
- Data shortfalls

Redefining concepts

Two concepts have remained relatively static within the injury prevention field, age and severity of injury. Both concepts are important in defining and measuring the impact of injury on at risk populations and both concepts have scope for refinement and advancement.

Developmental stage

Generally speaking age has been examined in terms of chronology. For ease of comparison, age ranges have typically been used and are usually based on an arbitrary division such as a 5-year age band. Injury varies with age because other factors, such as risk exposure, physical and mental capabilities and so on, also tend to vary with age. However, these associations with chronological age are not tight – two 14 year old girls, or two 74 year old men may respond differently to situations which will have differential effects on risk of injury. Also, age and injury are more closely linked at some periods of life (e.g., early childhood; emerging adulthood) than at others.

The concept of developmental stage recognises that age is a more complex risk factor for injury than has been previously acknowledged. As individuals age chronologically they go through a number of physical, psychological and emotional developmental stages.¹ The age ranges associated with developmental stage are not always the same for each individual and it has been suggested that injury profiles can be better understood according to the following age ranges:

- Pre-school 0–4 years
- School age 5–14 years
- Independent adolescents 15–17 years
- Young adulthood 18–24 years
- Working age 25–64 years
- Retired 65–74 years
- Elderly 75 + years.

Specific injury profiles are identifiable for each of the developmental stages.

Understanding the risk factors inherent in each developmental stage will assist policy and planning for injury prevention and assist in tailoring injury prevention programs to specific population groups.

Injury severity

Within surveillance, the concept of severity of injury has typically been represented by simple and imperfect approaches such as treating deaths and hospital admissions as proxies for degrees of severity, or regarding duration of stay in hospital as an indicative measure of severity. More rigorous approaches, based on probability of death, exist, and are being developed further and used more widely.²⁻⁴ Injury types are usually compared on the basis of the degree of severity according to these indicators.

The use of rates of death and admission to hospitals is a rather crude indicator of the severity of an injury. The usefulness of a severity indicator is dependent on the accuracy of the data on which it is based and its applicability in the planning area. For example, length of stay in hospital is typically used as an indicator of the severity of an injury yet it fails to accurately take into account transfers between hospitals and variations in clinical and administrative practice, which can inflate or deflate the severity

indicator for an injury cause.

Additionally, such indicators of severity take almost no account of the long-term consequences of injury, other than death. For example, some spinal cord injuries result in life long disability at an enormous cost to the health system, however the average length of stay in hospital may be comparatively short compared to other injuries from which full recovery is the norm.

Planning for future needs with respect to rehabilitation and other costs to the health system will be better assisted by the development of more sophisticated indicators of severity. The discussion paper identifies severity indicators as a priority area and encourages development of technically better and more useful indicators.

Cross cutting issues

This document proposes using population groups as the main conceptual framework within which to consider priorities for injury prevention. However, some issues are relevant to injury prevention more generally. For present purposes, we refer to these as ‘cross cutting issues’.

Cross cutting issues might not be suitable as declared priority areas, but they affect the potential for successful injury prevention in priority areas. Numerous topics could be considered. In the discussion paper, four diverse topics have been proposed. These are *monitoring and maintenance of successes, defining and measuring severity, equity issues and partnership development*.

Monitoring and maintaining successes

Significant advances have already been made in a number of injury areas. For example, certain types of injury are much less common than at certain times in the past (e.g. poisoning of children by iron preparations, burns associated with flammable nightwear, poisoning by barbiturates, drowning of older children and adults, many types of road deaths).

Attention to gains already made is

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important because success stories provide much of the basis for arguing that more gains are feasible, and they may provide models for how this can be done. It is also important because failure to 'keep an eye on' the maintenance of some types of preventive intervention could allow a well-managed problem to return.

In order for the reductions in specific injury areas to be maintained a degree of monitoring and maintenance is required. There are a number of aspects to this including the need to establish thresholds of acceptability in injury numbers, so that when/if levels rise again a flag within the database can signal a need for renewed investment in time and focus. However, case monitoring can only detect a recurrent problem after injury cases have begun to increase. Monitoring of hazards and exposures potentially provides a way to avoid this (e.g. periodic checks for return of flammable nightwear to the market).

Crediting agencies and jurisdictions for success in injury reduction through a program of success monitoring is likely to receive political support. Additionally there are potential financial savings to be made through pro-active management of injury prevalence through the use of early detection systems.

Key issues include establishing baseline criteria for success; development of monitoring systems, and provision of timely surveillance bulletins.

Defining and Measuring Severity

Definitions and measurement of the severity of an injury are important mechanisms in determining the cost of injury to the individual, in terms of pain and suffering, and to the health care system, in terms of ongoing financial support required. Precise and reliable monitoring of injury incidence can only be done if severity forms part of case definition. The inclusion of defining and measuring severity recognises that more work needs to be done on the basic tools of injury research.

Limitations in the current data collections are hampering progress in a number of areas. The main validated indicators of severity are limited to probability of death and less reliable information is often used (e.g., length of

stay in hospital).

Key issues include optimising the use of current data collections, and development and validation of meaningful severity indicators, which refer to non-fatal consequences of injury, as well as to threat to life.

Equity

Equity, in this context, refers to equity of access to, and provision of, injury intervention and prevention strategies, without prejudice on the basis of cultural background or socio-economic status. Socio-economic status⁵⁻⁸ and cultural background⁹ have been demonstrated to be factors in injury across all developmental stages.

The inclusion of equity as a cross cutting issue reflects the need to raise awareness of equity factors and encourage strategic beginnings. Key issues include recognition of the unique profile of injury within culturally and linguistically diverse population groups, and awareness of barriers to access to prevention and intervention strategies on the basis of socio-economic status and cultural background.

Partnership Development

All of the priority areas identified so far have one thing in common: the need and opportunity for partnership development. The priority areas proposed encourage a cross-jurisdictional approach to injury prevention and intervention and advance the concept of viewing injury problems from a whole-of-person or whole-of-community perspective.

Partnership development has been included to build on the 2001-2003 Plan and further foster linkages between policy domains. Opportunities for collaboration are abundant and include areas such as sport and recreation, transport, the workplace, consumer safety and the criminal justice system. Potential partnerships have already been identified in a large number of areas and initial forays made into collaboration with the National Aboriginal Health Strategy, the National Plan for Suicide Prevention, and the National Road Safety Strategy. Further opportunities exist within the health sector

(e.g. concerning alcohol and other drugs, physical activity, and patient safety).

Key issues include identifying areas of joint interest, Implementing collaboration, and evaluating the effectiveness of existing partnerships (e.g. how successfully have promoters been in engaging other stakeholders, what fraction of other funding opportunities, potentially available for injury prevention, have been earmarked for this purpose?).

Priority Injury Issues

Using the framework and criteria described above, six priority injury issues have been identified. These are:

- Children (0–14)
- Emerging adults (15–24)
- The elderly (75+)
- Aboriginal and Torres Strait Islander populations
- Rural and remote populations
- Alcohol and injury

Each of these issues is dealt with in detail in the discussion paper. The information provided includes the reasons why the issue has been included; developmental considerations; relevant surveillance and infrastructure issues; surveillance indicators such as deaths and hospitalisations, and characteristic patterns of injuries. The concept of cross-cutting issues is also applied to each of the priority areas.

Where available, data have been provided on the incidence of injury within each population group along with other surveillance indicators. It should be noted, however, that currently available data sources lend themselves variably to the purposes of this report. Previous reports which have been used as the basis for priority-setting for injury prevention have tended to be shaped very much by the ICD 'external causes' classification, and by mortality data (also more recently hospital inpatient data). This approach was justifiable but it is limited. It tends to highlight certain types of injury and risk factors and not others. It also tends not to take full account of the range of relevant criteria for selection of priority topics. In

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Trends in spinal injuries

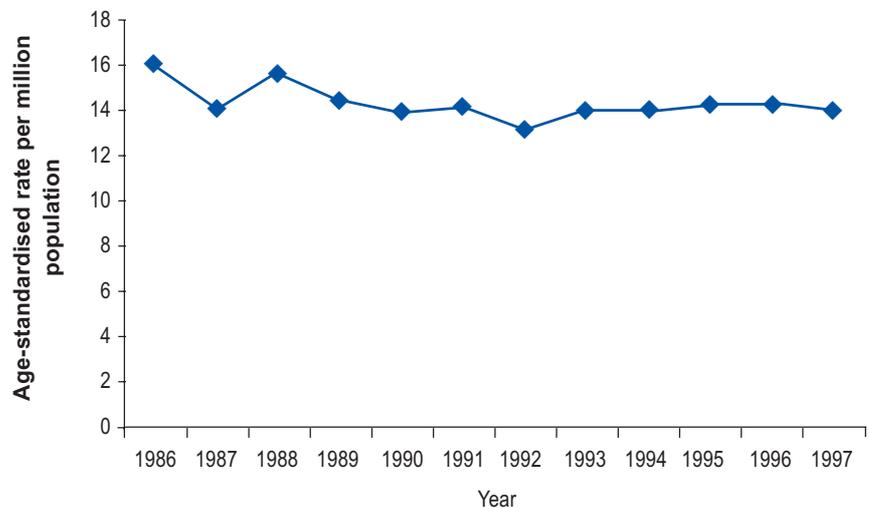
Spinal cord injury (SCI) is a significant public health problem in Australia. Although SCI is relatively rare, it is important due to the severity of the outcome in individual, social and economic terms. The Australian Spinal Cord Injury Register (ASCIR), established in 1995, enables the patterns and trends in SCI to be monitored.

NISU has recently published a report, *Trends in spinal cord injury, Australia 1986–1997*. The specific objective of the new publication is to present information on trends in SCI in Australia. It provides time-series information about the demographic features, causal factors and outcomes of SCI. It also illustrates how information on these parameters can provide new insights into the prevention and control of SCI and future research needs.

Injury mortality rates in Australia have declined substantially over the last 20 years.¹⁰ The largest contributor to this decline has been a substantial reduction in transport-related deaths, notably in young males and females.^{10–12} The rate of fall-related mortality has also declined among persons over the age of 65 years, both male and female,¹¹ although it has been reported using more recent data that the rate may have increased slightly since 1993.¹³ As transport and fall-related events are the most common causes of SCI, the mortality trends signal the potential for important changes in the incidence of SCI. Indeed, on the basis of those trends it might be expected that the overall rate of SCI would be declining, especially for transport-related causes in young males and females. It might also be expected that the rate of fall-related SCI in the elderly would have decreased among elderly males and females, although perhaps with a slight recent increase.

Of course, there are a number of reasons why the improved injury mortality experience of the population may not translate into a reduced incidence of SCI as reflected in the number of patients, or rate per head of population, that survive initial retrieval and transfer to hospital.

There may be a contrast in the specific causal factors important for SCI compared with deaths generally. In addition, it is possible that some of the 'fatalities saved' by improved medical retrieval, transfer and emergency care become survivors with SCI (e.g. ventilator dependent tetraplegics). If that were so, there might be a



Trend in the age-standardised rate of SCI; Australia 1986–1997 (excludes cases aged 0–14 years)

lower decrease (or, indeed an increase) in the SCI trend when compared with that observed for fatalities. This hypothesis has received no specific attention in the literature.

For these and other reasons it cannot be assumed that SCI would decrease to the same extent as fatalities.

The report includes trends information in relation to age and sex, cause, and neurological group.

Copies are available on the RCIS website: www.nisu.flinders.edu.au A limited number of printed copies are also available, on request, from RCIS, Tel: 08 8374 0970.

Inquiries should be directed to Ray Cripps at RCIS, Tel: 08 8374 0970, E-mail: raymond.cripps@flinders.edu.au

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this report, we have sought to take a different approach, based mainly on population sectors, but also highlighting a major risk factor (alcohol). This approach does not entirely 'go with the flow' of available data sources. Advantages of this are that it gives a different perspective, which (among other things) reveals limitations of current information (e.g., the lack of information on most risk factors and exposure). The other side of this coin is that data are not presently available to

illustrate many points for which data would be desirable.

Copies of the discussion paper are available on the RCIS website: www.nisu.flinders.edu.au Questions about the content of the report should be addressed to James Harrison at RCIS, Tel: 08 8374 0970; E-mail: james.harrison@flinders.edu.au

Using CATI for injury surveillance

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What is CATI?

Computer-assisted telephone interviewing (CATI) is a technique whereby traditional face-to-face or postal survey methods are replaced by surveys conducted over the telephone. Interview questions are stored in computer memory, recalled in programmable sequences, and displayed for the interviewer on a video display terminal. The computer memory, facilitating data collation and analysis. The CATI methodology has become an increasingly popular method of choice for many health surveys for reasons of cost, speed, flexibility and improved quality control.

A project undertaken by NISU for the National CATI Technical Reference Group has looked at the ways in which CATI has been applied in Australia and suggested ways forward with applying the technique for injury surveillance.

Australian CATI health surveys

CATI has been used in a number of health areas in Australia.¹⁴⁻¹⁶ In particular, the South Australian Social, Environmental and Risk Context Information System (SERCIS) has been used extensively in areas as diverse as diabetes, gambling and health risk factors, arthritis prevalence and medical services usage.¹⁷⁻²⁰ Injury incidence has been addressed by two statewide surveys, but only as minor components of these surveys.^{21,22} The 1998 *Health Monitoring Indicators* survey identified injury as a cause of chronic back-pain²² while the 2000 *Health & Wellbeing Survey* found that 17.2% of the South Australian population had sustained an injury in the last 12 months that required medical treatment.²¹ This study was conducted in tandem with surveys in Western Australia and the Northern Territory. While general health risk factors data were collected in these studies, current published analyses do not link injuries sustained with any specific cause or risk factor other than to note that no significant difference was detected in injury incidence between metropolitan/rural/remote regional classifications.^{21,23} Although the capacity for the SERCIS to be applied to injury and risk factors for injury has not been fully exploited to date, the system has been demonstrated to be highly reliable²⁴ and is a good model for future Australian CATI health surveys.

Risk factors for injury and the potential for CATI techniques

Age has been demonstrated to be a factor in injury incidence, younger children and older adults having higher rates of injury, as has gender, males sustaining higher rates of injuries than females in most age groups.²⁵⁻²⁷ Living in non-metropolitan regions and/or being of Aboriginal and Torres Strait Islander background have also been demonstrated to be factors in elevated risk of injury.^{28,29} Socio-economic status is also thought to be a factor in rates of injury incidence.^{30,31} However, it is important to note that these risk factors are unmodifiable. While useful for priority setting and some other purposes, it may be of more use to focus on modifiable behaviours and attitudes from an injury prevention point of view. Alcohol use is considered to be of influence on injury incidence,^{32,33} but as yet the strength

of this relationship as it pertains to certain types of injury is undetermined.³⁴ While contrary to exercise's role in other health issues, participation in sporting activities and vigorous exercising has been demonstrated to increase rates of injury. Research suggests that those undertaking very high levels of exercise being twice as likely to sustain an injury than those who do not undertake any exercise.³⁵ The above demographic factors and behaviours are considered to be common risk factors for a number of health issues, not only injury,³⁶⁻⁴¹ And as such, age, gender, region of residence, cultural identity, socio-economic status, body mass, exercise levels and alcohol and tobacco use must be necessarily included in any survey of health status and play an important role in injury risk factor surveillance.

Past studies of risk factors for injury have largely concentrated on specific types of risky behaviours, posing questions which ask the respondent to enumerate the number of times they may have engaged in such behaviours over a particular time-span (e.g. Koziol-McLain *et al.*)⁴² For example, core questions included in the 1999, 1997 and 1995 BRFSS⁴³ asked about how often the oldest child under 16 years of age in the household wore a helmet when riding a bicycle. Similarly, in 1995 a core question asked how often the oldest child under 16 used a car safety seat (if under 5) or seatbelt (if 5 or older) when they travelled in a car.⁴⁴ Many of the BRFSS injury-related questions in recent years have focused on firearm ownership and behaviours, and have been included in both the core and module components of the system. These include types of firearms owned, firearm storage (e.g. loaded or unloaded, securely locked away) and whether or not the firearm is carried on the person or in a motor vehicle.⁴⁴ Other injury topics in recent BRFSS surveys, though to a lesser degree than firearms, have included the use of seatbelts in vehicles, fire-safety behaviour and smoke alarm ownership, and poisoning prevention behaviours.⁴⁴ State-added questions in contemporary BRFSS surveys have expanded upon the topics broached in the national core and module injury components to include questions on injury incidence, types of injuries sustained and injury severity (type of treatment required), and helmet-use in activities other than cycling, e.g. snowboarding or in-line skating.⁴⁵ Other surveys appear to ask similar questions in similar ways,^{33,35} the authors of one study noting that they used "the traditional survey question relating to injuries in the last year which required medical attention...".³⁵

While these studies add to our understanding of 'risky' behaviours and conditions and provide the type of information that is useful for the purposes of priority setting, further information is required for the development of intervention programs. The CATI methodology is ideally suited to the surveillance of the population's knowledge and attitudes regarding injury and as such can place injury within a social context which can then be used in the planning and enhancement of injury prevention programs.⁴⁶ This tack has been taken by injury prevention researchers in New Zealand with the explanation that many studies have found that people generally

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believe that injuries “just happen” and as such injury prevention must seek to raise “awareness about injuries so that they are seen as preventable rather than an inevitable and unavoidable part of life”.⁴⁷ The authors used a CATI methodology to survey over 5,000 New Zealand households regarding injury prevention attitudes and awareness and report some promising results. Contrary to the above premise, the majority of householders surveyed (84%) did not view injury to be inevitable, yet beyond installing smoke alarms and having first aid kits in the home, comparatively few respondents reported practising other common methods of injury prevention, such as installing safety glass in windows and doors or having non-slip mats in bathrooms and showers.⁴⁷ Interestingly, while older people and people of lower socio-economic status were the most likely to report their homes as being ‘very safe’ or ‘reasonably safe’ they were also the most likely to report the belief that injuries were largely unpreventable.⁴⁷ While this finding requires further exploration, it has important implications for the direction, and effectiveness, of injury-prevention programs.

Current Australian risk factor research

Previous research conducted by NISU has collated existing Australian surveys addressing injury-related behaviours, knowledge and attitudes. This research was restricted to the current Strategic Injury Prevention Partnership (SIPP) priority areas, that is; falls in older people, falls in children, drowning and near drowning, and poisoning in children 0-4 years. Contacts were established for this study via a letter written to various injury prevention organisations around the nation.⁴⁸ The response rate from key contacts was considered to be poor.⁴⁸

Most respondents indicated that their injury prevention priorities were in line with the SIPP priority areas but few of the survey examples provided addressed risk factors as such, rather than incident characteristics of recently-sustained injuries. Suggested topics for further development within surveys addressing injury-related behaviours, knowledge and attitudes included knowledge relating to pool fencing legislation and poisoning risk-minimisation practices.

Input into future policy regarding SIPP priority areas for the period 2003-2005 is currently in development (see story on page 1).⁴⁹ The discussion document provides a population-based approach to injury prevention while maintaining continuity with the previous period’s priorities. Proposed priority areas are: the elderly (75+), children (0-14), emerging adults (15-24), the Aboriginal and Torres Strait Islander population, the rural and remote population, and alcohol and injury. Emphasised within the proposal is the importance of risk factor identification and intervention evaluation. We envisage that an injury-related CATI module is extremely well suited to application in these areas and recommend that development of specific question sets should take account of this emerging policy framework. For example, falls in the elderly was a priority area in the 2001-2003 SIPP policy and the elderly (75+) are a priority population flagged in the new proposal. Analyses of annual hospital separations, deaths data and the 2001 National Health Survey demonstrate an extreme rate of falls in this age group, confirming the area as a priority in injury prevention.^{25,50} In addition, there is a wealth of research which reports that exercise programs targeted to the elderly may help reduce the number of falls in this group.^{51,52}

However, there is also work which suggests that there are cultural differences within the age group which effect the degree to which people are prepared to undertake such falls-prevention.⁵³ Thus, having set a priority for falls prevention in the elderly on the basis of current injury surveillance, a CATI injury module can be used to assess knowledge and attitudes regarding exercise in the elderly population and to explore potential intervention possibilities. For example, the Lewis *et al.*⁵³ study reports that there were distinct cultural differences between types of preferred exercise and that language constituted a significant barrier for the ethnic elderly. Once such intervention programs have been developed and instituted, there is then a role for CATI in the evaluation and further development of the injury prevention strategy.

It is apparent in the above example then that we envisage that the types of questions asked in an injury-related CATI module will change according to the status of the injury prevention topic. That is, very different questions must be asked in order to help elucidate and validate priority areas than must be asked in order to guide the development of an intervention or to evaluate the performance of an injury prevention strategy. While the forthcoming SIPP priority areas have been suggested as a focus for the development of a CATI injury module, it is envisaged that the question-selection process will be a continuing task in coming months and further work on this issue is to be expected.

Enquiries about this study should be directed to Clare Bradley at RCIS, Tel: 08 8374 0970; E-mail: clare.bradley@flinders.edu.au

New on the RCIS Website

- ◆ National Injury Prevention Plan Priorities for 2004 and Beyond: Discussion Paper
- ◆ Trends in spinal cord injury, Australia 1986–1997

New Edition of Type of Occurrence Classification System

Tim Driscoll
ELMATOM Consulting, Sydney

A recent report prepared in collaboration with my colleagues from the Research Centre for Injury Studies at Flinders University and the Department of Epidemiology and Preventive Medicine at Monash University presents the results of a project commissioned by the National Occupational Health and Safety Commission (NOHSC) to review the *Type of Occurrence Classification System Version 2.1* (TOOCS 2.1), with the aim of developing a 3rd edition. The principal reason for the review was to revise the Nature of injury/disease codes to make them consistent with the *International Statistical Classification of Disease and Related Health Problems, Tenth revision* (ICD-10).

Background

Under the National Data Set for Compensation-based Statistics (NDS),⁵⁴ States and Territories provide information on a subset of accepted workers' compensation claims to NOHSC. This information is used as the basis of national statistics on workers. Compensation claims published by NOHSC, and in aspects of the Comparative Performance Monitoring publications.

The NDS information is the only on-going national source of information on work-related conditions. The information is used for identifying the main work-related disorders and the main circumstances producing work-related disorders, and to monitor these over time. Ideally, the information would underpin the development of preventative activities. The Type of Occurrence Classification System is the coding system used for this information.

Nature of injury/disease

In previous versions of TOOCS, the Nature of injury/disease coding has been based on the coding principles of the International Classification of Diseases 9th revision (ICD-9). The ninth revision has now been superseded by the tenth (ICD-10). An Australian clinical modification of ICD-10 (ICD-10-AM) is the coding system now used for most health data collections in Australia. The Review Group recommends that the Nature of injury/disease coding used in TOOCS 2.1 be replaced in TOOCS 3.0 by a coding system based on the coding principles of ICD-10-AM. Although the coding principles of ICD-10-AM have been adopted, TOOCS 3.0 is not a replication of ICD-10-AM, just as previous versions of TOOCS were not a replication of ICD-9. There are many reasons for this. These include that ICD-10-AM is uni-axial, with multiple concepts covered by a single variable, and so not directly comparable with TOOCS, which is multi-axial and generally has only one concept (or one main concept) covered by each variable; and that compensation data require a heavier focus on injuries, and much less detail on diseases, than is provided in ICD-10-AM. Nevertheless, TOOCS 3.0 contains considerably more detail on diseases, particularly musculoskeletal and psychiatric diseases, than was available in TOOCS 2.1, reflecting the expressed needs of jurisdictions and the perceived future requirements of compensation systems. The TOOCS 3.0 Nature codes are based heavily on a coding system developed by Victorian WorkCover, called the V-Codes, which also adapted ICD-10-AM coding principles to a workers. Compensation claims data system. However, considerable changes at the detailed level have been made to ensure TOOCS 3.0 is

applicable nationally, and to improve alignment with ICD-10-AM as much as possible. The numbering of codes in TOOCS 3.0 is not sequential, due to advice from jurisdictions that codes used in TOOCS 2.1 should not be repeated in TOOCS 3.0. This approach is designed to limit the possibility of miscoding and to decrease the costs associated with switching over to the new version of TOOCS. However, the codes remain hierarchical and logically grouped.

Bodily location of injury/disease

The only change made to the classification for Bodily location of injury/disease was the addition of a separate code for teeth. Previously, teeth were included within the category for mouth and were not separately identifiable.

Mechanism of incident

In previous versions of TOOCS, the Mechanism code has recorded the mechanism of injury/disease rather than the mechanism of incident, although specific rules governing the application of the codes meant that the final coding actually represented a mixture of the mechanism of injury/disease and mechanism of incident, depending on the circumstances involved. The Review Group concluded, and the jurisdictions agreed, that the mechanism of incident, that is the action or occurrence that best describes the way in which the incident or exposure occurred, is more likely to be what is targeted by prevention activity. For example, if a person tripped on a power cord and hit their head on the wall, it would be more reasonable to ensure power cords were taped down or secured out of walkways than to pad the walls to limit the injury caused by such an impact. As such, the explicit focus of this code in TOOCS 3.0 has been changed to the Mechanism of incident. This change relates predominantly to how the codes are applied rather than the codes themselves, although additional codes have also been added for:

- drowning/immersion;
- exposure to other environmental factors (includes factors such as lightning); and
- rollovers.

In addition, problems in TOOCS 2.1 relating to the coding of Mechanism when injuries were sustained in non-collision incidents involving vehicles (particularly ships) have been addressed in TOOCS 3.0 through the development of new coding guidelines and rules.

Agency of injury/disease and Breakdown agency

The Review Group has recommended that TOOCS 3.0 use the one set of agency codes for both Agency of injury/disease and Breakdown agency, as was the case in TOOCS 2.1. In previous versions of TOOCS, this has been a three-digit code that identified the object, substance or circumstance principally involved in the point at which things started to go wrong (Breakdown agency), and the object, substance or circumstance directly involved in inflicting the injury or disease (Agency of injury/disease). In TOOCS 3.0, these codes have been expanded to include a fourth digit, allowing more specific objects,

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Type of Occurrence Classification System

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substances or circumstances to be separately identified. The codes remain consistent with TOOCS 2.1 at the 3rd digit level, allowing jurisdictions to code as they are currently if they are not in a position to incorporate a fourth digit into their coding system.

The new codes are based on those used by NSW WorkCover, with some minor revisions to ensure alignment with TOOCS 2.1 at the third digit level. The index of this set of codes has the capacity to be expanded to include additional objects, substances and circumstances as identified by jurisdictions.

Other changes

The introductory section of the TOOCS documentation, including the coding rules and examples, have been up-dated to ensure consistency with the new version of TOOCS.

Implementation

The successful implementation of TOOCS 3.0 as a replacement for TOOCS 2.1 will require activity in several areas. Description, planning or conduct of this activity was not part of the project requirements, but is clearly needed. As a simple first step, it would be useful to inform the data providers (i.e. medical practitioners) of the new classification, the reasons behind its development, and the contribution to work-related health and safety that can be made by recording an accurate and detailed diagnosis for work-related conditions on all relevant medical certificates. Doctors' groups who could be usefully approached include the Australasian Faculty of Occupational Medicine, the Australian and New Zealand Society of Occupational Medicine, and the Royal Australian College of General Practitioners.

Subsequent steps in the implementation activity could reasonably include:

- production and dissemination of concordance tables; between TOOCS 2.1 and TOOCS 3.0;
- training of coders and data analysts; and
- field testing of codes.

Enquiries about this report can be directed to Helen Burbidge at the National Occupational Health & Safety Commission, Tel: 02 6279 1000, E-mail: helen.burbidge@nohsc.gov.au

Aboriginal and Torres Strait Islander Injury Prevention Workshop

The Commonwealth and Aboriginal and Torres Strait Islander Injury Prevention Advisory Committee (ATSIIIPAC), commissioned a national project to map injury prevention activity in Indigenous communities.

ATSIIIPAC arranged for the key findings of the draft report to be presented at the Aboriginal and Torres Strait Islander Injury Prevention Workshop that was held as part of the 6th National Conference on Injury Prevention and Control, in Perth on 18 March 2003.

The purpose of the Workshop was to present key findings from the Indigenous Injury Prevention Activity Project and to form part of the consultation process in the development of the National Indigenous Injury Prevention Plan. The Workshop was an ideal opportunity to present an overview of the report in a receptive forum to members of the Indigenous and injury communities and other key stakeholders.

Mr Tim Agius facilitated the Workshop and has submitted a summary report of the Workshop's proceedings. This includes the issues that were raised for discussion as the key findings from the Activity Project and also the underlying principles of the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2002.

The report also includes the slide show presentations conducted by:

- Dr Kathy Clapham and Mr Jerry Moller of New Directions in Health on the current status of activity in Indigenous injury prevention in Australia;
- Ms Pam Albany of NSW Health on the draft NSW Health Aboriginal Safety Promotion Strategy; and
- Associate Professor Ted Wilkes, the Chair of the National Drug Strategy Reference Group for Aboriginal and Torres Strait Islanders, on the complementary action plan to address Aboriginal and Torres Strait Islander substance misuse.

A copy of the report can be obtained by contacting Tania Haslam in the Injury Prevention Section of the Department of Health and Ageing, Tel: (02) 6289 8625, E-mail: tania.haslam@health.gov.au



Flinders Centre for Epidemiology & Biostatistics

The Flinders Centre for Epidemiology & Biostatistics (FCEB), of which RCIS is a member, is holding three events soon. The first of these, a joint venture between the Centre and the SA Department of Human Services, will take place on 27-28 October. A workshop, it will provide a forum for an examination of future directions for the linkage of data in the South Australian health system.

The other two events are one-day courses: on 3 November, an *Introduction to Epidemiology*, and on 4 November, instruction in the use of *Survey Research Methods*.

Further information about these events is available from the FCEB, Tel: 08 8204 5490; E-mail: fceb@flinders.edu.au or from the FCEB website: som.flinders.edu.au/FUSA/GP-evidence/FCEB

Paris hit by ICE

The most recent meeting of the International Collaborative Effort (ICE) on Injury Statistics was held in Paris in April of this year.

A key feature of the meeting was the introduction of a 5-year strategic plan for the ICE on Injury Statistics. As part of that

plan, new statements on the vision, mission and goal of the ICE were accepted.

Several papers were presented to the meeting and are available on the Internet:

- What is an injury?
- Selecting a main injury from the multiple causes of death
- Household injury survey comparison



ICE delegates at the Paris meeting

- Occupational ICE on Injury
- Proposed methodology for building multiple injury profiles
- Strategic Planning Work Group—summary of efforts to date
- Five-year strategic plan for ICE on Injury statistics components
- Incorporating disability measures into injury measurement

- International classification of external causes of injuries (ICECI): an update

- ECOSA Working group on quantifying post-injury levels of functioning and disability

- Developing a set of indicators for injuries/accidents for the European Union: a practical approach

- Update on injury registration in the Nordic countries

- ICE Injury Indicators Group—progress report, aspirations,

goals and strategy development

If you want to learn more, you can visit the ICE web pages: www.cdc.gov/nchs/advice.htm There you'll find detailed proceedings of the April meeting, along with information about the ICE, including work on specific projects, proceedings of earlier meetings and list of publications related to ICE work.

Poor vision and hip fractures

Research from overseas points to a high risk of hip fracture among older people with poor vision. A fact sheet from the Royal National Institute for the Blind and the Health Education Authority in the United Kingdom cites The Framingham study finding that the risk of hip fracture was doubled with poor and moderately impaired vision.⁵⁵ A major proportion of people (98%) aged 65 and older wear glasses⁵⁶ and 90% of blind and partially sighted people are aged over 60 years of age.⁵⁷ In 1997, in the UK there were 160,197 partially sighted people and 193,956 who were blind.⁵⁸

Recently, and more locally, injury risk has been one of the main themes of the Blue Mountains Eye Study. (Information about the study and a summary of its findings can be found at www.cvr.org.au). A recent finding from the Blue Mountains Eye Study is that over one-quarter of hip fractures in this cohort of Australians aged 49 years or older were attributable to poor visual acuity, defined as corrected acuity worse than 20/60.⁵⁹

Ivers and her colleagues have begun a randomised trial to assess the effect of improving vision on risk of falls. This trial will recruit 1,000 community dwelling people aged 75 years and older. They plan to conduct relatively simple tests of vision (including visual acuity, contrast sensitivity and

visual fields) and perform an eye examination, often in subjects' homes, and then arrange appropriate interventions (including new spectacles, cataract surgery, laser therapy and vision related home modifications and aids). Falls during 12 months of follow up will be ascertained with a falls calendar system.

Improving vision is likely to have other benefits besides preventing falls, including improved physical and social function and improved health related quality of life. If the intervention proves effective, the project has great potential to improve the health of many older people.

Hip fractures are the most common serious injury sustained by older Australians. In 1999/2000, hip fracture (ICD-10-AM code S72) was the principal diagnosis for 21,361 inpatient hospital episodes in Australia where the patient was aged 50 years or older. This condition is much more common at older ages, affecting fewer than one person in 3,000 per year at ages 50-59 years, about one in 200 at ages 70-79 and about one in 40 at older ages.⁶⁰

In the journals—recent Australian injury research

The following articles have appeared in peer reviewed journals since the beginning of 2003. We acknowledge our use of the excellent Internet resource Safetylit in compiling this list of articles: www.safetylit.org

Suicide and self harm:

- De Leo D, Dwyer J, Firman D, Neulinger K. Trends in hanging and firearm suicide rates in Australia: substitution of method? *Suicide and Life Threatening Behavior* 2003; 33(2): 151-164. Blaszczynski A, Farrell E. A Case Series of 44 Completed Gambling-Related Suicides. *Journal of Gambling Studies* 1998; 14(2): 93-109.
- Rowe L, Tonge B. Depression in adolescents. Key issues in assessment and management. *Australian Family Physician* 2003; 32(4):255-260.
- De Leo D. Struggling against suicide: the need for an integrative approach. *Crisis* 2002; 23(1): 23-31.
- Lambert G, Reid C, Kaye D, Jennings G, Esler M. Increased suicide rate in the middle-aged and its association with hours of sunlight. *American Journal of Psychiatry* 2003; 160(4):793-795.
- Goldney RD, Fisher LJ, Wilson DH, Cheok F. Mental health literacy of those with major depression and suicidal ideation: an impediment to help seeking. *Suicide and Life Threatening Behavior* 2002; 32(4): 394-402.
- Davidson JA. Presentation of near-hanging to an emergency department in the Northern Territory. *Emergency Medicine* 2003; 15(1):28-31.
- Carter GL, Issakidis C, Clover K. Correlates of youth suicide attempters in Australian community and clinical samples. *ANZ Journal of Psychiatry*. 2003; 37(3): 286-293.
- Maccallum F, Blaszczynski A. Pathological gambling and suicidality: an analysis of severity and lethality. *Suicide and Life Threatening Behavior* 2003; 33(1): 88-98.

Transport-related:

- Tay R, Champness P, Watson B. Personality and speeding: some policy considerations. *IATSS Res* 27(1):68-74.
- Newstead SV, Narayan S, Cameron MH, Farmer CM. U.S. Consumer Crash Test Results and Injury Risk in Police-Reported Crashes. *Traffic Injury Prevention* 2003; 4(2): 113-137.
- Desai AV, Ellis E, Wheatley JR, Grunstein RR. Fatal distraction: a case series of fatal fall-asleep road accidents and their medicolegal outcomes. *Medical Journal of Australia* 2003; 178(8): 396-399.
- Lam LT. Factors associated with fatal and injurious car crash among learner drivers in New South Wales, Australia. *Accident Analysis and Prevention* 2003; 35(3): 333-340.
- Bryant RA, Harvey AG. Gender differences in the relationship between acute stress disorder and posttraumatic stress disorder following motor vehicle accidents. *ANZ Journal of Psychiatry* 2003; 37(2): 226-229.
- Wood JM. Age and visual impairment decrease driving performance as measured on a closed-road circuit. *Human Factors* 2002; 44(3):482-494.
- Chan AO, Medicine M, Air TM, McFarlane AC. Post-traumatic stress disorder and its impact on the economic and health costs of motor vehicle accidents in South Australia. *J Clin Psychiatry* 2003; 64(2): 175-181.
- Blows S, Ivers RQ, Connor J, Ameratunga S, Norton R. Does periodic vehicle inspection reduce car crash injury? Evidence from the Auckland Car Crash Injury Study. *ANZ Journal of Public Health* 2003; 27(3): 323-327.
- Turner C, McClure R. Age and gender differences in risk-taking behavior as an explanation for high incidence of motor vehicle crashes as a driver in young males. *Injury Control and Safety Promotion* 2003; 123-130.
- Taylor DM, Bennett DM, Carter M, Garewal D. Mobile telephone use among Melbourne drivers: a preventable exposure to injury risk. *Medical Journal of Australia* 2003; 179(3):140-142.
- Kam BH. A disaggregate approach to crash rate analysis. *Accident Analysis and Prevention* 2003; 35(5):693-709.

Alcohol, drugs and accidental poisoning:

- Reith DM, Whyte I, Carter G. Repetition risk for adolescent self-poisoning: a multiple event survival analysis. *ANZ Journal of Psychiatry* 2003; 37(2): 212-218.
- Chien C, Marriott J, Ashby K, Ozanne-Smith J. Unintentional ingestion of over the counter medications in children less than 5 years old.

- J Paediatr Child Health* 2003; 39(4): 264-269.
- Sheedy DL, Garrick TM, Fortis AH, Harper CG. Changing trends in heroin-related deaths in Sydney, Australia-1995 to 1999. *American Journal of Addiction* 2003; 12(1): 52-59.
- Balit CR, Lynch CN, Isbister GK. Bupropion poisoning: a case series. *Medical Journal of Australia* 2003; 178(2): 61-63.
- White VM, Hill DJ, Effendi Y. Patterns of alcohol use among Australian secondary students: results of a 1999 prevalence study and comparisons with earlier years. *J Stud Alcohol* 2003; 64(1): 15-22.

Recreation and sports:

- Burns J, Keenan AM, Redmond AC. Factors associated with triathlon-related overuse injuries. *J Orthop Sports Phys Ther* 2003; 33(4): 177-184.
- Roe JP, Taylor TK, Edmunds IA, Cumming RG, Ruff SJ, Plunkett-Cole MD, Mikk M, Jones RF. Spinal and spinal cord injuries in horse riding: the New South Wales experience 1976-1996. *ANZ Journal of Surgery* 2003; 73(5): 331-334.
- Mummary WK, Schofield G, Spence JC. The epidemiology of medically attended sport and recreational injuries in Queensland. *J Sci Med Sport* 2002; 5(4): 307-320.

Research methods, surveillance and codes:

- Wang K, Lee AH, Yau KK, Carrivick PJ. A bivariate zero-inflated Poisson regression model to analyze occupational injuries. *Accidental Analysis and Prevention* 2003; 35(4): 625-629.

Rehabilitation:

- Tooth L, McKenna K, Geraghty T. Rehabilitation outcomes in traumatic spinal cord injury in Australia: functional status, length of stay and discharge setting. *Spinal Cord* 2003; 41(4): 220-230.

Accidental falls:

- Barnett A, Smith B, Lord SR, Williams M, Baumand A. Community-based group exercise improves balance and reduces falls in at-risk older people: a randomized controlled trial. *Age and Ageing*. 2003; 32(4):407-414.
- Clemson L, Cumming RG, Heard R. The development of an assessment to evaluate behavioral factors associated with falling. *American Journal of Occupational Therapy* 2003; 57(4): 380-388. Peel NM, Kassulke DJ, McClure RJ. Population based study of hospitalized fall related injuries in older people. *Injury Prevention* 2002; 8(4):280-283.
- Cameron ID, Cumming RG, Kurrle SE, Quine S, Lockwood K, Salkeld G, Finnegan. A randomized trial of hip protector use by frail older women living in their own homes. *Injury Prevention* 2003; 9(2): 138-141.
- Choy NL, Brauer S, Nitz J. Changes in postural stability in women aged 20 to 80 years. *J Gerontol A Biol Sci Med Sci* 2003; 58(6): M525-M530.

Home and consumer product safety:

- Stevenson MR, Leeb AH. Smoke alarms and residential fire mortality in the United States: an ecologic study. *Fire Safety Journal* 2003; 38(1): 43-52.
- Stevenson MR, Lee AH. Smoke alarms and residential fire mortality in the United States: an ecologic study. *Fire Safety Journal* 2003; 38(1): 43-52.

Pedestrian and bicycle issues:

- Curnow WJ. The efficacy of bicycle helmets against brain injury. *Accident Analysis and Prevention* 2003; 35(2): 287-292.

Occupational injury:

- Driscoll TR, Healey S, Mitchell RJ, Mandryk JA, Hendrie AL, Hull BP. Are the self-employed at higher risk of fatal work-related injury? *Safety Science* 2003; 41(6): 503-515. Driscoll T, Mitchell R, Mandryk J, Healey S, Hendrie L, Hull B. Coverage of work related fatalities in Australia by compensation and occupational health and safety agencies. *Occup Environ Med* 2003; 60(3): 195-200.

Coronial information sheds light on fatal hazard

Over the years, the *Monitor* has reported on developments in relation to the National Coronial Information System (NCIS), from well before its inception to its current status as a fully functioning resource. An inquiry received by NISU presented an opportunity to put the NCIS through its paces in relation to a practical situation. The inquiry related to deaths of infants due to strangulation by blind-cords. The response, as outlined in the box below, highlights some of the strengths and limitations of the NCIS when compared to the Australian Bureau of Statistics' Deaths Collection. The verdict ... One of the major advantages of the NCIS, is its capacity to identify deaths occurring due to relatively uncommon situations together with its

capability for providing access to detailed information in relation to the circumstances leading to death. An additional advantage, is that the information obtained can be promptly brought to the attention of Australian coroners.

Unfortunately, since the NCIS was not implemented until July 2000, cases occurring before this date were unable to be identified. There is currently no public access to Queensland cases in the NCIS and consequently any cases in that state meeting the criteria as outlined above were also unable to be identified. (This limitation is likely to be overcome by the end of 2003.) Another limitation identified via this inquiry is the lag time between case notification and case closure. One of the identified cases was still open over

10 months after the date of death and consequently there was little detailed information about this case.

Searching for relevant cases proved to be relatively straightforward by selecting the appropriate categories within the Mechanism and Object fields. However, if information in one or both of these fields is incorrect or missing, searching for cases through the attached text documents is somewhat less efficient and more time consuming.

Inquiries about the information contained in the box below should be directed to Geoff Henley at RCIS, Tel: 08 8374 0970; E-mail: geoffrey.henley@flinders.edu.au

Deaths of infants and young children due to strangulation by blind-cords

An urgent request was made for the RCIS to supply information regarding deaths of infants and young children due to strangulation of infants by blind-cords.

Routine data on deaths and hospital admissions

Routine deaths data (the ABS Deaths Data Collection) were not useful because ICD-10 (World Health Organization 1992), the version currently used to code deaths, does not include categories that can be used to identify cases of this type specifically. ICD-10 categories W76 "Other accidental hanging and strangulation" and W75 "Accidental suffocation and strangulation in bed" are the most likely categories to contain the deaths of interest, but they are not specific for the objects that produce strangulation.

National Coroners Information System (NCIS)

The data specificity and detail necessary to provide useful information for this request is provided by the classifications in the NCIS. In addition to the coded data, documents attached to many records in the NCIS can be examined for additional information.

Two project members independently conducted searches of the NCIS independently, and each found the same three cases of interest. Considerable detail was available on two of the cases, but the third case was Open, and so little information was accessible. The NCIS commenced full operation from July 2000, so earlier cases would not be expected in this source. Data submission from Queensland began a year

after this, but NCIS users are not yet permitted to access the Queensland data in the NCIS.

The two cases for which detailed information is available have similarities: both children were about one and a half years old, and both died in their cot after having become entangled in the cord of a window furnishing during a period in which they had been left alone for a day-time sleep. The furnishing is described as a concertina blind in one case and a curtain in the other. Entanglement appears to have been with an internal cord of the concertina blind (i.e. one of the cords that run through holes in the segments of the blind). Both children were reported to have been unconscious or dead by the time they were discovered.

An additional case was found among the Coronial inquest Findings in South Australia published on the Coroner's web-site.⁶¹ This case, which dated from 1999, was similar to the two cases described above. The child had been put into his cot for a day-time sleep, and was found a short time later with the cord of a nearby curtain around his neck. The Coroner, Mr Chivell, included a public warning in his Finding regarding the danger of toddlers sleeping near blinds and curtains, and recommended that parents consult a relevant KidSafe brochure released as part of the Safe Sleeping Campaign.

Published scientific literature

A literature search identified several relevant research articles.⁶²⁻⁶⁴ In addition, the US CPSC has worked with industry to develop safer designs for new blinds, and methods to improve the safety of existing ones,⁶⁵ whilst since 1989 Health Canada has received reports of 19 deaths and 17 near-miss incidents of child strangulation by window-

blind and curtain cords. The agency has issued a Health Advisory notice on the subject.

Summary and conclusion

The risk of strangulation of young children in cords of blinds and other window coverings has been recognised for about a decade, in Australia and elsewhere. By the mid-1990s the problem had been characterised in sufficient detail to enable the development of preventive responses and to prompt their implementation, initially in the United States. Preventive responses initially focused on risks associated with loops in pull-cords. More recently, this has been supplemented by preventive responses focusing on risks associated with the internal cords that run through the slats of venetian blinds. Preventive responses exist for new products (by safer design) and to enable existing products to be modified.

Available data indicate that this cause has led to at least four deaths of one to two year old children in Australia since 1999. (The total number of deaths in Australia from all causes at ages one or two years in 2001 was 171.)

The hazard was considered a continuing preventable cause of child mortality that warranted further preventive attention. In accordance with a condition under which data users have access to data in the NCIS, the issue was brought to the attention of Australian coroners in July 2003, as an "Issue of Concern to Public Health and Safety".

OUR COSTLIEST EPIDEMIC

Fred Ehrlich
Chairman

Falls Injury Prevention Working Group
Royal Australasian College of Physicians

The reason the flagship of Australian medicine, the venerable Royal Australasian College of Physicians, invited Fellows, representatives of the other medical Colleges, specialists' societies and allied health professional groups to attend a workshop in early May, was the rising concern by some practitioners about the escalating cost, both human and financial, of a looming and generally overlooked epidemic—falls.

Falls injury of the elderly population does not sound as 'sexy' as other health burdens such as cancer or heart disease, but can be a source of untold misery, pain, disability and, too frequently, death.

Thus, in 1997/98, some 17,000 persons over the age of 65 were admitted to NSW hospitals for more than one day, representing 14% of all hospitalisations due to injury. This rate is three times as great as admissions due to motor vehicle crashes.⁶⁶

Falls injury comes close to representing the second costliest item in public hospital expenditure (more than \$325 million each year⁶⁷). This is because hip fracture requires expensive surgical procedures and lengthy hospitalisation followed by weeks of rehabilitation.

The current bill to the Australian taxpayer is estimated at 2.4 billion annually⁶⁸ if one adds supplemental costs such as outpatients treatment, doctors' fees, physiotherapy, carers and nursing home expenses, etc.

It will eventually represent a figure of some \$80 a year for every wage earner.

What is more important is the escalating age of the population, bearing in mind that the fastest population increase is in the over 65 year olds.

Within this segment the number of over 85 year olds are increasing even faster.⁶⁹ By 2010 it is estimated that health costs will be 50% greater for this reason alone.

Thus, Australian Bureau of Statistics estimates show that the numbers of persons 65 and over will rise from 2.4 million in 2001 to 3.1 million in 2011 and 4.2 million in 2022. The latter accounts for a 39% increase: the "baby boomer" phenomenon. The proportionate increases in the



85+ group are from 260,000 in 2001 to 390,000 in 2011 and 480,000 in 2021⁷⁰.

The most compelling aspect of all this is that much of this problem can be dealt with much more effectively than it is now; by assessing risk factors to prevent many falls, by targeting interventions to lessen the severity of injury due to a fall and by managing injuries more efficiently. We also need health promotion and public education measures.

There is ample, valid research information about the causes of falls and about preventive measures, which have been shown to be effective. Targeted exercise can to some extent, prevent falls injury in those who have deficiencies in balance or strength.⁷¹

Practical advice—reducing the use of psychotropic medications, avoiding stairs while wearing bifocal spectacles—can reduce the propensity to fall. We also know that attention to footwear is important. Modifications to the home, eliminating domestic hazards such as loose rugs, electric cords are useful. Keeping a domestic pet in sight and even knowing the location of tiny grandchildren crawling about are sensible preoccupations. Another aspect of prevention is the need to strengthen bones, so that if a fall does occur, it need not necessarily lead to fracture.

Osteoporosis increases in prevalence in direct proportion to age, as do the falls.

Preventing osteoporosis requires long-term measures, bearing in mind that the fragility of bones depends to some extent on the degree to which bone mass has been attained earlier in life.

Peak bone mass is achieved well before the age of 30 and will not be maintained if there has not been an adequate intake of calcium in the diet. Dairy foods are the best source. Younger women frequently neglect their nutrients while dieting in order to achieve unnatural sylph-like figures mooted to be the current ideal of feminine beauty.

Unless this perception can be altered the prevalence of osteoporosis in 50 years' time will be even greater than it is now, bearing in mind that the condition is much commoner in women than in men.

Environmental hazards on our streets need to be addressed. I have been impressed in my medico-legal practice by the number of people who have sustained serious fractures by stumbling over cracks in pavements or unmarked holes or obstructions across their paths. Local authorities may well save moneys paid out as compensation by investing more in making our footpaths safer.

The College is therefore working to develop specific policy proposals for health professionals, in an attempt to influence key organisations in the greater community, ranging from local government to industry. The fitness, design and food industries can all contribute.

Fortunately we have seen a philosophical commitment from State and Commonwealth health authorities. NSW Health has demonstrated best practice in policy and programs.

However a comprehensive national approach, ultimately the responsibility of the federal government, is crucial if we are to have a meaningful impact on this impending crisis.

Professor Ehrlich can be contacted at the Department of Rehabilitation, Aged and Extended Care at the University of New South Wales, Tel: 02 9332 2479, E-mail: f.ehrlich@unsw.edu.au

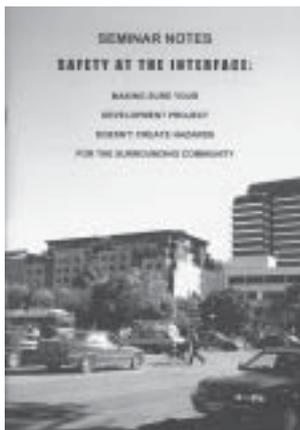
Something to read ...?

Rural, Regional and Remote Health: Information Framework and Indicators



The Australian Institute of Health and Welfare has released the first version of a framework whose purpose is to develop a formal understanding of the types of information that are important for understanding rural health; review the usefulness of available data collections towards this understanding, so laying the foundations for an ability to report in a systematic way on rural health issues; and to assist in identifying gaps in the data that prevent effective reporting of rural health issues. The full document is available on the AIHW website: www.aihw.gov.au/publications/

Safety at the interface



"After more than 16 years of documenting the victims of hazardous environments, my colleagues and I are sick of addressing environmental problems retrospectively. We have therefore embarked on a project that will take us in a new community-safety direction. We have decided to actively influence the urban planners, architects, building inspectors, builders, designers, and insurers who are responsible for our built environment. Moreover, we are arranging to work with the relevant faculties of our three universities to enhance the curriculum options for students in the building arts and sciences.

*To this end we have just published a 9000-word booklet on the topic of safety in the built environment. Short, sharp and FUNNY. 31 colour photos, 50 laughs. A useful resource for practitioners, and a great teaching tool. The title of the booklet is **Safety at the Interface: making sure your development project doesn't create hazards for the surrounding community.**"*

Ron Somers

Copies of this book are available from Ron Somers at the Injury Surveillance and Control Unit in the SA Department of Human Services, Tel: 08 8226 6361; Fax: 08 8226 6291; E-mail: ron.somers@dhs.sa.gov.au The book costs \$22.00 including postage.

Australian Drug Trends 2002



This is the latest in this series of reports from the Illicit Drug Reporting System (IDRS) which monitors illicit drug markets across Australia. IDRS consists of three components: (1) interviews with injecting drugs users (IDU); (2) interviews with key informants, professionals who have regular contact with illicit drug users through their work; and (3) analysis and examination of indicator data sources related to illicit drugs, such as National Household Survey data on drug use, opioid overdose data, purity of seizures of illicit drugs made by law enforcement agencies. The report is available from the National Drug and Alcohol Research Centre, Tel: 02 9385 0333 for \$12.00. The executive summary is available on the Internet: notes.med.unsw.edu.au/ndarc.nsf/website/IDRS.national

Jurisdictional reports against the Aboriginal and Torres Strait Islander health performance indicators

This is the final edition of three reports (previously released for the 1998 and 1999 periods) by jurisdictions against the interim set of Aboriginal and Torres Strait Islander health performance indicators, which includes more than 50 indicators across nine categories of mortality, morbidity, access to health services, health service impacts, workforce developments, risk factors, intersectoral issues, community development and quality of service provisions. For many jurisdictions, the data

Something to read ...?

required to report on the indicators are not available or are of poor quality. In such cases, jurisdictions have agreed to report on initiatives to improve data quality and availability. Improving data to facilitate reporting on health performance indicators is therefore a key driver of the implementation process for the *National Indigenous Health Information Plan*.

The report is available free of charge, in hard copy, from the Australian Institute of Health and Welfare, Tel: (02) 6244 1032

Mortality Atlas, Australia

The Australian Bureau of Statistics has produced this reference for users in interpreting causes of death in Australia. Through the use of maps and commentary, the publication presents standardised death rates for Statistical Divisions and Statistical Subdivisions in Australia for the period 1997–2000.

Underlying and multiple causes of death are presented for the top 10 and other topical causes of death—including some major causes of injury. The *Mortality Atlas* (Cat. no. 3318.0) is available from the ABS Bookshop, Tel: 1300 135 070.

Australian Hospital Statistics 2001-02

This series is produced by the Australian Institute of Health and Welfare. The latest version is now available from Info Access (Toll free Tel: 132 447) for \$50. (Catalogue no. HSE-25.)

National Health Data Dictionary Version 12

The latest in this series has just been published. In two volumes, it is available from Information Access (Toll Free Tel: 132 447) for \$60. (Catalogue no. HWI-43.)

Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2003



The 4th edition of *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* provides a unique overview of the health and welfare of Australia's Indigenous population. The report draws on the extensive surveys and censuses conducted by the Australian Bureau of Statistics and the range of data held by the Australian Institute of Health and Welfare. The result is a publication that covers topics as diverse as population statistics, housing and infrastructure, community services and housing assistance, health status, death and sickness, and the availability, resourcing and use of services.

The report can be downloaded from the AIHW website: www.aihw.gov.au/publications/ Printed copies are available for \$60 from the ABS Bookshop (ABS Cat. No. 4704.0), Tel: 1300 135 070, E-mail: maria.shpakoff@abs.gov.au

In the journals ...

Continued from page 6

Sparrow WA, Bradshaw EJ, Lamoureux E, Tirosh O. Ageing effects on the attention demands of walking. *Hum Mov Sci* 2002; 21(5-6): 961-72.

Wood JM. Age and visual impairment decrease driving performance as measured on a closed-road circuit. *Hum Factors* 2002; 482-494.

Drowning and water safety:

Stevenson MR, Rimajova M, Edgecombe D, Vickery K. Childhood drowning: barriers surrounding private swimming pools. *Pediatrics* 2003; 111(2): E115-119.

Taylor DM, O'Toole KS, Ryan CM. Experienced Scuba Divers in Australia and the United States Suffer considerable injury and morbidity. *Journal of Wilderness and Environmental Medicine* 2003; 14(2): 83-88.

Bites and stings:

Bailey PM, Little M, Jelinek GA, Wilce JA. Jellyfish envenoming syndromes: unknown toxic mechanisms and unproven therapies. *Med J Aust* 2003; 178(1): 34-37.

Burns:

Fraser JF, Choo KL, Sutch D, Kimble RM. The morning after the night before: campfires revisited. *Med J Aust* 2003; 178(1): 30.

Henderson P, Mc Conville H, Hohlrriegel N, Fraser JF, Kimble RM. Flammable liquid burns in children. *Burns* 2003; 29(4): 349-52

Childhood injury:

Slack-Smith LM, Read AW, Stanley FJ. A prospective study of absence for illness and injury in child care children. *Child Care Health Dev* 2002; 28(6): 487-94.

Recreation:

Schneider T. Snow skiing injuries. *Australian Family Physician* 2003; 32(7): 499-502.

Lim J, Puttaswamy V, Gizzi M, Christie L, Croker W, Crowe P. Patter of Equestrian injuries presenting to a Sydney teaching hospital. *ANZ Journal of Surgery* 2003; 73(8): 567-571.

Commentaries:

Johnson IR. Research, policy-making and intervention programming in injury prevention: a classic case of sub-optimization. *IATSS Res* 2003; 27(1): 58-65.

Pearn J. Children and war. *J Paediatr Child Health* 2003; 39(3): 166-172.

Methods and techniques:

Gabbe BJ, Cameron PA, Finch CF. Review article: the status of the Glasgow Coma Scale. *Emergency Medicine* 2003; 15(4):353-360.

Culvenor J. Comparison of team and individual judgments of solutions to safety problems. *Safety Science* 2003; 41(6):543-556.

Note: where available, Internet addresses have been provided below for conference websites. For those meetings that don't have their own website, detailed descriptions of the events are normally available at our website: www.nisu.flinders.edu.au/events/

Evaluation Workshop

8 October 2003

Adelaide

Contact: Helma Hooper, South Australian Community Health Research Unit, Flinders University, Tel: +61 8 8204 5988, Fax: +61 8 8374 0230, E-Mail: helma.hooper@fmc.sa.gov.au
Website: www.sachru.sa.gov.au

22nd World Road Congress

19-25 October 2003

Durban, South Africa

Contact: Fax: +33 149 00 0202, E-Mail: piarc@wanadoo.fr

3rd National Sporting Injury Prevention Conference

25-30 October 2003

Canberra

Contact: Kate Gulliver, Conference Manager, Sports Medicine Australia, Tel: +61 2 6230 4650, Fax: +61 2 6230 5908, E-Mail: sma.conf@sma.org.au Website: www.sma.org.au/2003conference

Workshop: Future Directions for the linkage of data in the South Australian health system

27-28 October 2003

Adelaide

Contact: Kristin McLaughlin, Flinders Centre

for Epidemiology & Biostatistics, Tel +61 8 8204 5490, E-mail: fceb@flinders.edu.au

Diversity in Health 2003

27-29 October 2003

Sydney

Contact: Diversity in Health Conference Secretariat, Fax: 02 9280 0533, E-Mail: diversity2003@pharmaevents.com.au
Website: www.tmhc.nsw.gov.au/diversity.htm

Injury Prevention Network of Aotearoa New Zealand Conference

29-31 October 2003

Wellington, New Zealand

Contact: Valerie Norton, National Coordinator, IPNANZ, Tel: +64 4 472 2562; E-mail: v.norton@ipn.org.nz Website: www.ipn.org.nz

Course: Introduction to Epidemiology

3 November 2003

Adelaide

Contact: Kristin McLaughlin, Flinders Centre for Epidemiology & Biostatistics, Tel +61 8 8204 5490, E-mail: fceb@flinders.edu.au

Course: Survey Research Methods

4 November

Adelaide

Contact: Kristin McLaughlin, Flinders Centre for Epidemiology & Biostatistics, Tel +61 8 8204 5490, E-mail: fceb@flinders.edu.au

National Conference on Juvenile Justice

1-2 December 2003

Sydney

Contact: Conference Coordinators, Tel: 02 6292 9000, Fax: 02 6292 9002, E-Mail: confco@austarmetro.com.au

Website: www.aic.gov.au/conferences/

Kidsafe National Playground Conference 2004

22-23 March 2004

Sydney

Contact: Playground Advisory Unit, Kidsafe New South Wales Inc. Tel: 02 9845 0890, Website: www.kidsafensw.org

13th International Safe Communities Conference

2-4 June 2004

Prague, Czech Republic

Contact: 13SafeComm Conference Secretariat, Tel: +420 224 942 575, Fax: +420 224 942 550, E-Mail: safe@cbttravel.cz Website: www.13safecomm.com

7th World Conference on Injury Prevention and Safety Promotion

6-9 June 2004

Vienna, Austria

Deadline for abstracts: 30 September 2003.
Contact: Fax: +43 1 715 66 44 30; E-Mail: safety2004@sicherleben.at
Website: www.safety2004.info

7th Australian Injury Prevention Conference and Pacific Rim Safe Communities Conference

15-17 September 2004

Mackay, Queensland

Contact: Maria Lamari, Conference Secretariat, PO Box 3090, Norman Park QLD 4170, Fax: +617 3847 2148, Website: www.nisu.flinders.edu.au/ainconference2004

References

- 1 Moller J. 1992. Childhood injury prevention: The role of the community. *Australian Early Childhood*. 17.
- 2 Kim Y, Jung Y, et al. 2000. Validation of the International Classification of Diseases 10th Edition-based Injury Severity Scores (ICISS). *Journal of Trauma* 48: 280-5.
- 3 Osler T, Rutledge R, et al. 1996. ICISS: An international classification of disease-based injury severity score. *Journal of Trauma* 41: 380-8.
- 4 Stephenson SC, Langley JD, Civil ID. 2002. Comparing measures of injury severity for use with large databases. *Journal of Trauma-Injury Infection & Critical Care*. 53:326-32.
- 5 Mathers C. 1994a. *Health differentials among adult Australians aged 25-64 years. Rep. 1*, Australian Institute of Health and Welfare, Canberra.
- 6 Mathers C. 1994b. *Health differentials among older Australians. Rep. 2*, Australian Institute of Health and Welfare, Canberra.
- 7 Mathers C. 1995. *Health differentials among Australian children. Rep. 3*, Australian Institute of Health and Welfare, Canberra.
- 8 Mathers C. 1996. *Health differentials among young Australian adults. Rep. 4*, Australian Institute of Health and Welfare, Canberra.
- 9 Lewis M, Szabo R, Weiner K, McCall L, Piterman L. 1997. Cultural barriers to exercise amongst the ethnic elderly. *Internet Journal of Health Promotion*.
- 10 Australian Institute of Health and Welfare. 2000. *Australia's Health 2000: the seventh biennial health report of the Australian Institute of Health and Welfare*. AIHW, Canberra.
- 11 Bordeaux S, Harrison J. 1998. Injury mortality, Australia 1995. *Australian Injury Prevention Bulletin*, Issue 17. Australian Institute of Health and Welfare, Canberra.
- 12 Federal Office of Road Safety. 1998. *The history of road fatalities in Australia*. FORS, Canberra.
- 13 Cripps R, Carman, J. 2001. *Falls by the elderly in Australia: trends and data for 1998*. Injury Research and Statistics Series. Australian Institute of Health and Welfare, Canberra.
- 14 Kirke K. Use of the Cancer Help Line—a computer assisted telephone interview (CATI) survey. *Cancer Forum* 24:19-20. 2000.
- 15 Robertson B, Forbes A, Sinclair M, Black J, Veitch M, et al. 2000. How well does a telephone questionnaire measure drinking water intake? *ANZ Journal of Public Health* 24:619-22.
- 16 Watson W, L., Ozanne-Smith J. 1997. *The Cost of Injury to Victoria. Rep. 124*, Monash University Accident Research Centre, Clayton, Victoria.
- 17 Dal Grande E, Woollacott T, Taylor A, Starr G. 2001. *Diabetes and Health Risk Factors 1997 & 1998: South Australian health goals & targets health priority areas*. South Australian Department of Human Services, Epidemiology Branch, Adelaide.
- 18 Gill T, Hickling J, Taylor A, Brown I. 2002. *Aspects of Medical Services Useage in South Australia*. South Australian Department of Human Services Centre for Population Studies in Epidemiology, Research and Evaluation Branch, Adelaide.
- 19 Gill T, Taylor A, Leach G, Parsons J. 2003. *Arthritis in South Australia. Who has it & what is the impact?* South Australian Department of Human Services, Population Research and Outcome Studies Unit, Adelaide, et al. 2003.
- 20 Taylor A, Dal Grande E, Gill T, Delfabbro P, Glenn V, et al. 2001. *Gambling patterns of South Australians and associated health indicators*. South Australian Department of Human Services.
- 21 Dal Grande E, Taylor A, Wilson D. 2002. *South Australian Health & Wellbeing Survey: December 2000*. Centre for Population Studies in Epidemiology, South Australian Department of Human Services, Adelaide.
- 22 Taylor A, Dal Grande E, Woollacott T, Starr G. 1998a. *South Australian Health Goals and Targets Health Monitoring Indicators. Report 1*. South Australian Department of Human Services, Epidemiology Branch, Adelaide.
- 23 Daly A, Saunders D, Roberts L. 2001. *2000 Collaborative Health and Wellbeing Survey: An Overview*. Health Department of Western Australia Report, Perth.
- 24 Starr G, Dal Grande E, Taylor AW, Wilson DH. 1999. Reliability of self-reported behavioural health risk factors in a South Australian telephone survey. *ANZ Journal of Public Health* 23:528-30.
- 25 Australian Bureau of Statistics. 2002. *National Health Survey—Summary of Results, Australia*. 4364.0, Australian Bureau of Statistics, Canberra.
- 26 Helps Y, Cripps R, Harrison J. 2002. *Hospital separations due to injury and poisoning, Australia 1999-00*. Injury Research and Statistics Series Number 15. AIHW cat. no. INCAT 48, Australian Institute of Health and Welfare, Adelaide.
- 27 Moller J. 1995. Injury among 15 to 29 year old males. *Australian Injury Prevention Bulletin* xxx
- 28 Moller J. 1994. The spatial distribution of injury deaths in Australia: urban, rural and remote areas. *Australian Injury Prevention Bulletin* 8:1-8.
- 29 Moller J. 1996. *Understanding national injury data regarding Aboriginal and Torres Strait Islander peoples*. AIHW Cat no. INJ3, Australian Institute of Health and Welfare.
- 30 Cubbin C, LeClerc FB, Smith GS. 2000. Socioeconomic status and injury mortality: individual and neighbourhood determinants. *Journal of Epidemiology and Community Health* 54:517-24.
- 31 Lalloo R, Sheiham A. 2003. Risk factors for childhood major and minor head and other injuries in a nationally representative sample. *Injury* 34:261-6.
- 32 Chikritzhs T, Jonas H, et al. 2000. Alcohol-caused deaths and hospitalisations in Australia, 1990-1997. National Alcohol Indicators Project Technical Report No. 1, National Drug Research Institute, Perth.
- 33 McLeod R, Stockwell T, Rooney R, Stevens M, Phillips M, Jelinek G. 2003. The influence of extrinsic and intrinsic risk factors on the probability of sustaining an injury. *Accident Analysis & Prevention* 35:71-80.
- 34 Driscoll T, Steenkamp M, Harrison JE. 2003. *Alcohol and water safety*. Commonwealth of Australia, Canberra.
- 35 Plugge E, Stewart-Brown S, Knight M, Fletcher L. 2002. Injury morbidity in 18-64-year olds: impact and risk factors. *Journal of Public Health Medicine* 24: 27-33. et al. 2002.
- 36 Braun B, Zimmermann M, Kretschmer N, Spargo R, Smith R, Gracey M. 1996. Risk Factors for Diabetes and Cardiovascular Disease in Young Australian Aborigines: a 5-year follow-up study. *Diabetes Care* 19:472-9.
- 37 Commonwealth Department of Health and Aged Care. 2001. *National Injury Prevention Plan: Priorities for 2001-2003*. Department of Health and Aged Care, Canberra.
- 38 Mathers C. 1995. *Health Differentials among Australian children*. Health Monitoring Series No. 3, Australian Institute of Health and Welfare, Canberra, ACT.
- 39 Mathers C, de Looper M. 1994. Health differentials among older Australians. Health Monitoring Series No. 2, Australian Institute of Health and Welfare, Canberra, ACT.
- 40 Mathers C, Merton C. 1994. *Health differentials among adult Australians aged 25-64 years*. Health Monitoring Series No. 1, Australian Institute of Health and Welfare, Canberra, ACT.
- 41 National Expert Advisory Committee on Alcohol. 2001. *Alcohol in Australia: issues and strategies: a background paper to the National alcohol strategy: a plan for action 2001 to 2003/04*. Commonwealth Department of Health and Aged Care, Canberra.
- 42 Koziol-McLain J, Brand D, Morgan D, Leff M, Lowenstein SR. 2000. Measuring injury risk factors: question reliability in a statewide sample. *Injury prevention* 6:148-50.
- 43 Behavioral Risk Factors Surveillance System (BRFSS), Centers for Disease Control, Atlanta, Georgia, USA.
- 44 Centers for Disease Control. 2002. *Behavioral Risk factor surveillance system: Historical Questions Search*. US Department of Health and Human Services, Centers for Disease Control and Prevention.
- 45 CSTE. 2002. *(Behavioral Risk Factor Surveillance System) State Added Questions*. Council of State and Territory Epidemiologists.
- 46 Butchart A, Kruger J, Lekoba R. 2000. Perceptions of injury causes and solutions in a Johannesburg township: implications for prevention. *Social Science and Medicine* 50:331-44.
- 47 Hooper R, Coggan CA, Adams B. 2003. Injury prevention attitudes and awareness in New Zealand. *Injury Prevention* 9:42-7.
- 48 O'Connor P. unpublished. *Australian Injury Prevention Survey*. National Injury Surveillance Unit, Australian Institute of Health and Welfare, Canberra.
- 49 Pointer S, Harrison J, Bradley C. 2003. *National Injury Prevention Plan Priorities for 2003 and Beyond: Discussion paper*. National Injury Surveillance Unit, Australian Institute of Health and Welfare, Canberra.
- 50 Cripps R, Carman J. 2001. *Falls by the elderly in Australia: Trends and data for 1998*. Australian Institute of Health and Welfare, Adelaide.
- 51 Deery HA, Day LM, Fildes BN. 2000. An impact evaluation of a falls prevention program among older people. *Accident Analysis and Prevention* 32:427-33.
- 52 Shigematsu R, Chang ML, Yabushita N, Sakai T, Nakagaichi M, et al. 2002. Dance-based aerobic exercise may improve indices of falling risk in older women. *Age and Ageing* 31:261-6.
- 53 Lewis MV, Szabo RA, Weiner KR, McCall L, Piterman L. 1997. Cultural barriers to exercise amongst the ethnic elderly. *Internet J Health Promot* 20.
- 54 National Occupational Health and Safety Commission. 1987. *National Data Set for Compensation-based Statistics. First Edition*. Canberra: Australian Government Publishing Service.
- 55 Felson DT, Anderson JJ, Hannan MT et al. Impaired vision and hip fracture: The Framingham Study. *Journal of the American Geriatric Society*, 37:495-500, 1989.
- 56 *General Household Survey 1986*. The Stationery Office, 1989.
- 57 RNIB. *Losing sight of blindness*. 1997.
- 58 Department of Health, *Personal Social Services* (England); Welsh Office, *Physical Disability Register* (Wales); *Social Work Services Group*, Scottish Office (Scotland).
- 59 Ivers R, Cumming R, et al. Visual risk factors for hip fracture in older people. *Journal of the American Geriatrics Society* 51(3):356-63.
- 60 National Injury Surveillance Unit, unpublished data.
- 61 www.courts.sa.gov.au/courts/coroner/findings/findings_2000/alsford.finding.htm
- 62 Moore L and Byard R. (1993). Pathological findings in hanging and wedging deaths in infants and young children. *American journal of Forensic Medicine and Pathology* 14(4): 296-302.
- 63 Byard, R. W., S. Beal, et al. (1994). "Potentially dangerous sleeping environments and accidental asphyxia in infancy and early childhood." *Archives of Disease in Childhood* 71(6): 497-500
- 64 Rauchschalbe, R. and N. C. Mann (1997). "Pediatric window-cord strangulations in the United States, 1981-1995." *JAMA* 277(21): 1696-8.
- 65 Window Covering Manufacturers Association Inc. (1996). *American National Standard for safety of corded window covering products ANSI/WCMA A100.1-1996*. New York, Window Covering Manufacturers Association Inc.
- 66 Preventing Injuries from falls in Older people, NSW Health (2001)
- 67 Moller J. 1998. *Estimating costs of injury by cause 1995-1996*. NSW Health Department Injury Prevention and Policy Unit, Sydney.
- 68 Commonwealth Department of Health and Aged Care. *An analysis on research preventing falls and falls injury in older people: community, residential and aged care settings*. Commonwealth Department of Health and Aged Care Canberra 2000
- 69 *NSW Public Health Bulletin* 13:1-2 Jan-Feb 2002 NSW Health
- 70 *Older Australia at a Glance Source*. Australian Bureau of Statistics (2002).
- 71 Lord SR, Sherington C and Menz H. *Falls in Older People Risk Factors and Strategies for Prevention*. Cambridge University Press 2001.

Editor's Note

The *Injury Issues Monitor* is the journal of the Research Centre for Injury Studies at the Flinders University of South Australia.

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Letters to the Editor are welcome.
Editor: Renate Kreisfeld



ISSN No 1039-4885
AIHW Cat. No. INJ54