1 **TITLE**

2 The Injury Workforce in Western Australia: findings from a cross-sectional survey

3

4 **ABSTRACT**

5 **Issue addressed:** Since 1986, injury prevention and control has been classified as a National Health Priority. However,
6 no reviews into the injury prevention workforce have been conducted in Australia since 2011 and to date; none has
7 focused specifically on the injury prevention and safety promotion sector in Western Australia (WA). This research
8 sought to bridge this gap in the literature by reviewing the scope of the injury prevention and safety promotion
9 workforce in WA to gain a greater understanding of sector characteristics, work and needs.

10 **Methods:** An online, cross-sectional survey was conducted between mid-January and mid-March 2018. Participants
11 were required to be: 1) based in WA or have a program running within WA; and 2) working in injury prevention and
12 safety promotion relating to programs, policy or legislation development, implementation, and/or evaluation within
13 falls, road trauma, mental health suicide and self-harm, violence, poisoning, drowning, burns, and community safety.

14 **Results:** The research found that participants were predominantly female (82%), aged 40 years or older (66.1%) and
15 were employed full-time (55.6%). The majority of participants worked in falls prevention (38.5%), alcohol and other
16 drugs (38.0%), injury in general (31.8%) and community safety (30.7%).

17 **Conclusions:** Findings demonstrate significant heterogeneity with a core workforce supported by a range of non-core
18 and indirect actors. Identifying characteristics and needs of the workforce supports coordinated capacity building to
19 implement effective injury prevention and safety promotion initiatives. With this being the first review of the
20 workforce in WA, this paper also highlights the need to more regularly audit the sector to determine its breadth and
21 composition.

22 **So what?** In light of the recent announcement by the Commonwealth for a new national Injury Prevention Strategy,
23 this study provides timely insights into the injury prevention and safety promotion sector in WA.

24

25 **SUMMARY**

26 This research sought to better understand the profile of the injury prevention and safety promotion workforce in WA
27 to assist with workforce planning and capacity building. Findings demonstrate significant heterogeneity within the
28 workforce and highlight the need to more regularly audit the sector to determine its breadth and composition.

29

30 **KEYWORDS**

31 injury prevention, workforce, public health, health promotion, capacity building

32

INTRODUCTION

Since 1986, injury prevention and control has been classified as a National Health Priority in Australia. Despite its significance as a public health issue,[1] it has been suggested that injury prevention has received insufficient attention in the research literature and is inadequately represented in national and jurisdictional public health strategies. As Wesson et al. (2013) have noted *"there is need to place injury prevention at the forefront of public health initiatives"*.[2]

The recent "Special Edition: Injury Prevention and Health Promotion" in the Health Promotion Journal of Australia highlighted the range of challenges currently being addressed in the injury prevention and safety promotion sector. Injury is a leading cause of mortality in Australia and is frequently preventable.[3] The most common causes of injury related deaths are falls, suicide, transport crashes and poisons, but also includes drowning, burns and scalds, self-harm and violence.[4] Injuries are also strongly associated with decreased productivity levels, poorer mental health and increased medical costs.[5] That is, injury burden extends beyond the individual and has significant social and economic consequences for the broader community.[2] Whilst limited research makes it difficult to determine, the lifetime costs of injuries sustained in Western Australia (WA) in 2012 alone was estimated to be $9.6 billion.[6]

A sufficiently sized and skilled workforce is required to achieve injury prevention and safety promotion targets and ultimately, positive health outcomes for the community.[7, 8] The National Injury Prevention and Safety Promotion Plan 2004-14[9] acknowledged the workforce's diversity, the need for training and the importance of strengthening its capabilities. However, this is now outdated and Australia lacks a current national plan despite the major contribution that injury makes to mortality and morbidity.

At a jurisdictional level, the WA Health Promotion Strategic Framework 2017–2021 sets out WA Health's direction to reduce preventable chronic disease and injury. The plan highlights the need to develop the injury prevention and safer communities sector through strategic coordination, building partnerships and workforce development *"that will support communication, ensure consistency of public health messaging, maximise the impact of limited resources, and minimise unnecessary duplication."*[10] The World Health Organisation (WHO) safe communities model consists of a coordinated approach, based on engagement with local governments, to support community safety and injury prevention.

Several public health and health promotion workforce reviews have been completed, including a national review of the injury prevention workforce in 2001.[11] Key findings from this review included: difficulties in defining workforce boundaries; recognition of the need for greater collaboration across the sector; the impact of limited funding; and the need for improved workforce development and training. However, no further reviews have been conducted in Australia within the last 17 years and to date, none have focused specifically on the injury prevention and safety promotion sector in WA.

69 Clearly establishing the parameters of the WA injury prevention and safety promotion workforce will assist in

70 achieving a more collaborative sector able to adequately address injury prevention and safety promotion. This study

71 sought to better understand the profile of the injury prevention and safety promotion workforce in WA to assist with

72 workforce planning and capacity building. Specifically the research documented the characteristics of the injury

73 prevention and safety promotion workforce in WA including: a) professional background, b) qualifications, c) key

74 role activities, d) geographic location, e) target groups, f) context/setting, g) leading injury issues, and h) challenges

75 for the sector and work roles.

76

77 **METHODS**

78

79 **Participants**

80 Participants were required to be involved in injury prevention (consistent with the definition of injury by the Australian

81 Institute of Health and Welfare) or safety promotion in WA by way of programs, policy or legislation development,

82 implementation or evaluation. Injury topic areas were identified for targeted recruitment across the workforce,

83 including falls, road trauma, mental health, suicide and self-harm, violence, poisoning, drowning, burns and local

84 government community safety. Potential research participants were sourced from a database managed by, the peak

85 non-government injury prevention and safety promotion agency in WA; the agency's networks; and via a Google

86 search of WA injury prevention or safety promotion organisations. To recruit participants, 717 emails were distributed

87 from the database.

88

89 **Procedure**

90 Potential participants were sent an invitation email explaining the study and its objectives between January and

91 March 2018. The email contained a hyperlink to online Qualtrics survey software[12] and also a request to forward the

92 email to colleagues working in the injury prevention and safety promotion (snowball sampling). Once participants

93 clicked on the link they were provided with information about confidentiality and their rights prior to commencing

94 the survey. Initially, 725 surveys were distributed to stakeholders from the database of sector workers within injury

95 prevention and safety promotion, including areas of falls, road trauma, burns, poisonings, violence, drowning, injury

96 in general, mental health, alcohol, community safety, Aboriginal and Torres Strait Islander organisations, and local

97 governments. Reminder emails were sent out two and four weeks post initial email.

98

99 The survey was also promoted by the peak body non-government injury prevention and safety promotion agency via

100 social media (Twitter and Facebook), newsletters, and organisational events within the sector. This was included

101 within five Injury Matters eNewsletters and nine social media posts over the four weeks of recruitment. The survey

102 was also promoted within 12 external agency newsletters and at eight injury prevention networks. The survey took

103 approximately 15 minutes to complete. Ethics approval was obtained from the Curtin University Human Research

104 Ethics Committee (RDHS-70-15) and the Sir Charles Gairdner Hospital Human Research Ethics Committee (2016-

105 062).

106

Survey Instrument

108 The survey tool was adapted from previously trialled instruments [11, 13-18] identified via a comprehensive search of six
109 databases using relevant key words. It was checked for face and content validity by members of the research team
110 (n=5) and via a one hour focus group with experts and members of the sector (n=5). It was then trialled with members
111 of the sector from academia, state government and local government (n=3) and modified as required. Domains of
112 inquiry were: training and qualification; current role; organisation; job challenges and satisfaction; collaboration;
113 current injury issues in the participant's role; community injury issues; and future needs.

114

Data analysis

116 Participant demographics and responses to questions were cleaned and analysed. Descriptive statistics were generated
117 using IBM SPSS Version 23.0[19] and open-ended responses were coded and categorised.

118

RESULTS

120 Overall 230 participants responded, Of the 230 participants, 82.6% (n=190) identified as working within the injury
121 prevention and safety promotion sector, while 17.4% (n=40) did not identify as a part of the sector and skipped to the
122 end of the survey. Reasons that participants did not identify as a part of the sector included, *'neither my role or*
123 *organisation is part of the sector'* (5.7%), *'But my organisation does work in the sector'* (6.5%), or *'But a specific*
124 *area of injury is part of my role'* (5.2%).

125

Participant Profile

127 Participants were predominantly female (82%; n=155), aged 40 years or older (66.1%, n=125) and held a tertiary
128 degree (82.1%, n=115). Just under a third (31.9%; n=51) had worked in the sector for five to 10 years and just over
129 half worked full time (55.6%, n=89). However, 41.9% (n=67) of participants stated they only spend a total of one day
130 per week working in injury prevention or safety promotion. An officer job level (21.3%, n=38) had the highest
131 representation, followed (14.0%, n=25) by a Manger and Coordinator (14.0%, n=25) (see Table 1).

132

133   **INSERT TABLE 1** Participant profile

134

Organisation profile

136 Falls prevention (49.7%, n=99), alcohol and other drugs (46.2%, n=92), general injury (42.2%, n=84) and community
137 safety (41.7%, n=83) were the most frequently nominated areas of focus for organisations. Those who responded
138 'other' (n=14.7%) stated that their organisation focused on the injury areas of public health (n=1), crime prevention
139 (n=1), rehabilitation (n=1), and mental health (n=1). The majority of injury organisations were non-government
140 organisations (NGOs) (25.3%, n=40), state government (19.6%, n=31), hospital/medical centres (19%, n=30) or local
141 government (17.7%, n=28). Funding for these organisations predominantly came from state government (72%, n=113)
142 (see Table 2).

143

144   **INSERT TABLE 2** Organisation profile

145

146   **Target groups**

147   Of the nine target groups identified, general community (54.3%, n=94), adults aged 25 to 64 years (53.2%, n=92),

148   adults aged 65+ (49.7%, n=86) and adolescents aged 15 to 24 years (48%, n=83) were evenly represented. Other target

149   groups included Aboriginal and Torres Strait Islander people (42.2%, n=73), rural and remote populations (39.9%,

150   n=69), workforce (38.7%, n=67) and culturally and linguistically diverse (CALD) groups (32.9%, n=53). Within these

151   populations groups, participants indicated working at an individual (60.1%, n=104), group, or sessions with

152   organisations (58.4%, n=101) and community (52%, n=90) level (see Table 3).

153

154   **INSERT TABLE 3** Target group focus

155

156   **Community injury issues**

157   Nominated community injury issues (n=131) were categorised into three key areas: 1) specific injury areas; 2) risk

158   factors contributing to injury; and 3) larger systemic issues (see Table 4).

159   - Identified specific community injury areas (n=90) were alcohol and other drugs (n=42), road trauma
160   (including on and off road, cycling and pedestrian safety) (n=33), falls prevention (n=26), suicide and non-
161   suicidal self-injury (n=19), violence (n=20), drowning (n=7) and mental health (n=6)
162   - Identified community risk factors for injury (n=39) included low levels of awareness and understanding of
163   the risk of injury (n=12), lack of community support (n=4), specific risks such as driving fatigue (n=3), driver
164   inattention (n=3), overmedicated elderly persons (n=1), driving and mobile phone use (n=1), lack of seatbelt
165   use (n=1) and peer pressure (n=1).
166   - Identified larger systemic injury issues (n=15) were ineffective treatment for individuals with mental health
167   or substance misuse difficulties (n=7), lack of services (n=5), budget cuts and limited resources (n=2), the
168   need for increased public awareness around injury prevention (n=2), problems with equipment prescription
169   (n=1), long waiting lists for community based services (n=1) and low community collaboration and
170   engagement (n=1).

171

172   **Injury role challenges**

173   Challenges nominated by participants in undertaking their role (n=139) were categorised as 1) internal work issues,

174   2) community issues, 3) external system issues, 4) sector awareness and 5) low injury topic awareness.

175   - Internal work issues (n=69) were those such as staffing (n=16) and lack of resourcing (n=8).
176   - Community issues (n=54) were those such as alcohol and other drugs (n=19), road safety (n=8), lack of
177   knowledge and attitudes towards injury prevention (n=7) and community engagement with injury prevention
178   (n=6).
179   - External systems issues (n=38) included funding (n=23) and policy (n=4).

180   •   Sector awareness of injury prevention and safety promotion included misunderstanding of what injury
181   prevention is or needing to raise sector profile (n=16).
182   •   Poor injury topic knowledge (n=15).

183

184   **INSERT TABLE 4** Identified leading community injury prevention issues and challenges

185

186 **DISCUSSION**

187 The aim of this research was to understand the characteristics of the injury prevention and safety promotion workforce

188 in WA to assist with workforce planning and capacity building. We found that participants were predominantly female,

189 aged 40 years or older, held a tertiary qualification, employed full time and had spent five to ten years working in the

190 injury prevention and safety promotion sector. The majority of participants worked in falls prevention, alcohol and

191 other drugs, injury in general and community safety and spent two or less days focusing specifically on injury

192 prevention and safety promotion. This indicates that the workforce is highly educated, experienced, working across a

193 range of areas but have limited time dedicated specifically to work with an injury focus (e.g. one day a week dedicated

194 to injury). As with previous findings about the prevention workforce[18, 20] and historical national findings about the

195 injury prevention workforce,[11] this research suggests that the WA injury prevention and safety promotion workforce

196 is highly multidisciplinary with porous boundaries to other sectors. The heterogeneity across the injury prevention and

197 safety promotion workforce disciplines presents a range of inherent difficulties, including adequately monitoring

198 sector needs and trend and measurement of individual and collective impact of programs on health outcomes.

199

200 The surveyed workforce contained a variety of organisations (NGOs, state government, hospitals/medical centres, and

201 local government) and disciplines (including public health, allied health, clinical services). Participants reported

202 conducting a wide variety of activities (such as education and training, community engagement, program planning

203 and implementation) at individual, group and community levels. Few practitioners reported that they identified as

204 injury prevention or safety promotion specialists (those who had specific qualifications or registration in or whose

205 whole role focused on injury prevention or safety promotion). This diversity has been captured in previous research,

206 with the injury prevention workforce being described as consisting of three distinct groups: leaders/champions, the

207 direct workforce (researchers, practitioners and policy makers) and the indirect workforce (whose roles indirectly

208 impact on injury outcomes but who may not identify with the workforce per se).[11]

209

210 Previous research has also suggested that a lack of specialist workforce may reduce effectiveness of programs and

211 services.[8] However, this may also present a range of benefits and opportunities to expand capacity in injury prevention

212 and safety promotion efforts across broader sectors beyond health and to capitalise on the indirect components of the

213 workforce. For example, the opportunity to create multidisciplinary approaches to address issues,[21, 22] for different

214 organisations to align their policies to support injury prevention and safety promotion,[10] and to work across a wider

215 range of settings, including with and in organisations whose primary purpose is not health related.[18] In WA, this sector

216   diversity has facilitated partnerships between non-for-profit stakeholders and government departments, resulting in a

217   reduction across a number of risk factors.[23]

218

219   Previous research has described the challenges of quantifying the public health, health promotion and prevention

220   workforces,[7, 8, 11, 18, 20] particularly with no mandated requirement for registration of practitioners and only fairly recent

221   inroads towards self-regulation in health promotion.[7, 24] Since the last attempt at the national level to quantify and

222   classify the injury prevention workforce,[11] it appears that some resources such as a national directory of practitioners

223   are no longer available. Due to classification difficulties and the significant influence of the non-core or indirect

224   components of the workforce, size is difficult to accurately enumerate; this has also been found in research about the

225   broader prevention workforce.[11, 18, 20] This would suggest opportunities for further research to develop some effective

226   measures for the size and scope of the workforce, which is important for workforce planning and capacity building.

227   Having an agreed definition of injury may assist in addressing this issue.[11]

228

229   As with previous research,[8] a range of human, financial and organisational factors were identified in this research as

230   issues for the injury prevention and safety promotion workforce. These broadly related to 1) internal work issues; 2)

231   external systems; 3) low injury topic knowledge; 4) sector awareness of injury prevention; and 5) community.

232   Participants identified leading community injury issues in three key areas: 1) injury topics: specific injury areas; 2)

233   risk factors contributing to injury; and 3) larger systemic issues. This provides further support to the literature, which

234   has identified the need for workforce development, inter-sectoral collaboration, community development and capacity

235   building to improve the efficacy of the public health workforce.[9, 10, 22, 23] There is also a significant need for targeted

236   interventions for specific groups, such as Aboriginal and Torres Strait Islander people and individuals in remote or

237   regional areas.[6, 10, 11, 18, 20, 23] Some of these issues cannot be addressed easily without systemic consideration of

238   workforce planning and resourcing.[25] The establishment of stronger partnerships with the non-core components of the

239   workforce to address gaps in service, particularly in areas lacking stable, experienced staffing may ameliorate some

240   of these issues. Further, some leading injury areas will require policy and advocacy solutions, which presents a role

241   for the sector collectively and peak injury prevention and safety promotion agencies to lead. To build momentum,

242   peak agencies have a unique role in providing sector-wide strategic direction and harnessing the disparate components

243   of the workforce. This approach may require specific championing by and to those who are in positions of influence

244   over the allocation and direction of injury prevention and safety promotion resources.

245

246   As a limitation, recruitment methods consisted of a snowball sampling, leaving the participants dependent on networks

247   and participant engagement to promote. Despite active efforts to promote the survey across all areas of the sector, this

248   may limit access to portions of the injury prevention and safety promotion sectors, as seen with limited responses from

249   occupational health and safety industry. Additionally, response rate was unable to be calculated due to snowball

250   technique. A low response rate may also be influenced from participants' lack of identification and resonance within

251   the injury prevention and safety promotion sector.

252

CONCLUSION

The purpose of this research was to describe the current state of the injury prevention and safety promotion workforce in WA, including the characteristics and activities of individuals and organisations. It also describes the community profile, including identified target groups, leading community injury issues and challenges. Findings demonstrate significant heterogeneity with a core workforce disciplines supported by a range of non-core and indirect actors, such as non-specialists in injury prevention and/or those who only work part-time in the sector. Consequently while there is an integral role for injury prevention and safety promotion specific organisations, it must continue to be supported by a variety of broader organisations that operate in the prevention space and beyond.

It is vital to continue to understand the structures and systems that act as barriers and enablers to effective injury prevention and safety promotion endeavours. However viewing the injury prevention and safety promotion sector as a system composed of individuals and organisations requires an understanding of relationships and networks, and how these change and evolve according to context and time.[18] Going forward, recognising and exploring the range of core and non-core actors connected to this sector is critical to evaluate their impact on the multiple socio-ecological determinants that influence injury and safety. More regular auditing of the sector to determine its breadth and composition may assist to address these issues and facilitate more effective workforce planning.

This research has provided the first step to exploring these issues. However, as Fortington and colleagues[26] assert, injury prevention is global and interdisciplinary in scope. It follows that to achieve effective public health action; a diverse, multidisciplinary, adequately staffed and skilled workforce is required.[22] The World Conference on Injury Prevention and Safety Promotion 2018, co-hosted by the World Health Organization (WHO) in Bangkok, acknowledges an international recognition of the need for further work in the injury prevention and safety promotion field and a commitment to funding in this area. In light of the recent announcement by the Commonwealth for a new National Injury Prevention Strategy, this study provides timely insights into the injury prevention and safety promotion sector in Western Australia.

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336 **TABLES**

337

338   **TABLE 1** Participant profile

Age	n=189	%
20 -29 years	22	11.6
30 - 39 years	42	22.2
40 years +	125	66.1
Gender	**n=189**	**%**
Male	34	18
Female	155	82
Highest formal qualification	**n=140**	**%**
High School	7	5
Vocational	6	4.3
Tertiary	115	82.1
Time working in area	**n=160**	**%**
Less than 5 years	58	36.2
5-10 years	51	31.9
Greater than 10 years	51	31.9
Employed	**n=160**	**%**
Full time	89	55.6
Part time	42	26.3
dCasual	10	6.3
Voluntary	5	3.1
Days spent working on injury prevention or safety promotion	**n=160**	**%**
1 day	67	41.9
2 days	16	10
3 days	24	15
4 days	14	8.75
5 days	40	25
Job level	n=178	%
Officer	38	21.3
Manager	25	14
Coordinator	25	14
Chair / Chief Executive Officer (CEO)	8	4.4
Consultant	4	2.2
Senior Officer	4	2.2
Discipline/Profession	**n=178**	**%**
Public Health	41	23
Allied Health	24	13.5
Clinical services	19	10.7
Occupational health and safety	14	7.9
Home and community services	11	6.2
Activities within current role *	**n=160**	**%**
Education and training	118	73.8
Community engagement	92	57.5
Program planning and implementation	88	55.0
Data collection and analysis	82	51.3
Evaluation of programs or interventions	76	47.5
Communications or media	70	43.8
Health and wellbeing	68	42.5
Advocacy*	63	39.4

Research	51	31.9
Secure and manage funds	36	22.5
Public policy	35	21.9

*Note: *participants were able to select more than one response for each category*

TABLE 2 Organisation profile

Organisation type	n=158	%
Non-government organisation or community group (NGO)	40	25.3
State government	31	19.6
Hospital or medical centre	30	19
Local government	28	17.7
Tertiary or research institution or technical education provider	12	7.6
Private organisation	9	5.7
Emergency services	1	0.6
Other	7	4.4
Location work undertaken*	**n=157**	**%**
Metropolitan Areas	58	36.9
Regional Areas	52	33.1
Metropolitan & Regional Areas	47	29.9
Funding type	**n=157**	**%**
State government	113	72
Funding body (grants)	37	23.6
Federal government	30	19.1
Fee for service	29	18.5
Donations	21	13.4
Memberships	10	6.4
Sponsoring agency/department	8	5.1
Other	19	12.1

Note: participants were able to select more than one response for each category

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364   **TABLE 3** Target group focus

Target group	n=173	%
General community	94	54.3
Adults 25-64	92	53.2
Older adults 65+	86	49.7
Adolescents and young adults 15-24	83	48
Aboriginal and Torres Strait Islander people	73	42.2
Rural and remote populations	69	39.9
Workforce	67	38.7
Culturally and linguistically diverse	57	32.9
Children 0-14	53	30.6
Other	6	3.5
Engagement with target population	**n=173**	**%**
Individual – one-on-one	104	60.1
Group	101	58.4
Community	90	52.0
Population or State	57	32.9
Other	13	7.5

365   *Note: participants were able to select more than one response for each category*
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388 **TABLE 4** Identified leading community injury prevention issues and challenges

Injury issues	n=131
Specific injury topics	90
Alcohol and other drugs	42
Road trauma	33
Falls prevention	26
Mental health including Suicide and NSSI	25
Violence including domestic and interpersonal violence	20
Drowning	7
Specific risk factors for injury	39
Larger systemic issues	15
Identified challenges to community injury prevention	**n=139**
Internal work issues	69
Community Issues	53
External systems	38
Sector awareness	16
Low injury topic knowledge	15

389 *Note: participants were able to select more than one response for each category*
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391