

Community Injury Prevention in New Plymouth District

Assessing the Needs

**Velma McClellan
Caroline Maskill
Ian Hodges**

RESEARCH & EVALUATION SERVICES Ltd



HealthSearch

Summary of Report, December 2001

REPORT SUMMARY

This report aims to assist Tui Ora and the Injury Safe Advisory Group to identify the types of injuries, population groups and injury locations that should be given priority in the work of a community injury prevention programme in New Plymouth District.

The information in the report comes from three main sources:

- research literature and other documentation on previous New Zealand and overseas community injury prevention programmes
- available statistical data on injuries in New Plymouth District
- consultation with key people and organisations in New Plymouth District with an interest in injury and injury prevention.

What is community-based injury prevention?

Community-based injury prevention is when people and organisations located in a district, city, town or neighbourhood work together to design and implement strategies to reduce the incidence or severity of injury in their population.

Building on the social work tradition of community development (Bjaras 1992), community injury prevention emphasises the use of *intersectoral collaboration* and *community participation*. Community members define the injury problems they consider important. They then build awareness and enthusiasm amongst other local people and organisations to take ownership of the problems and their solutions (Simpson 1999; Coggan and Simpson 1999).

This contrasts with other approaches to injury prevention that rely on centralised, top-down approaches, such as laws and regulations (e.g. compulsory seat belt wearing) or national education or media campaigns (Moller 1995).

The WHO Safe Communities model

During the 1980s, in parallel with other developments such as the Healthy Cities movement and the release of the Ottawa Charter on Health Promotion, the community injury prevention approach pioneered in Falköping was further refined, evolving into what is today known as the “Safe Communities” model for community injury prevention.

Key organisations and individuals involved in this work included the World Health Organization (WHO), programme managers in the various Swedish community-based injury initiatives, public health specialists from the Karolinska Institutet at the Department of Social Medicine in Stockholm, and Dr Jerry Moller from Australia.

In 1989 in Stockholm, at the First World Conference on Accident and Injury Prevention, which included 500 delegates from 50 countries, the Manifesto For Safe Communities was issued (Moller 1995) and, in 1991, the First International Conference on Safe Communities was held in Falköping.

The WHO has continued to take the lead in supporting the development of the Safe Communities concept internationally. Today, the WHO Collaborating Centre on Community Safety Promotion, based at Stockholm's Karolinska Institutet, sponsors the Safe Communities network. This network consists of all communities around the world designated as WHO Safe Communities. These Safe Communities are required to:

- form a cross sectoral group responsible for injury prevention
- involve the local community network
- address all ages, surroundings and situations
- address the concerns of high-risk groups (such as children and the elderly), high-risk environments and aim to ensure equity for vulnerable groups
- have a mechanism to document the frequency and causes of injuries
- take a long-term approach
- undertake evaluations that include indicators showing effects and provide information on the process as it advances
- identify relevant organisations in the community and assess their potential for participation in the programme
- ensure the participation of the health care community in both the registration of injuries and the injury prevention programme
- aim to involve all levels of the community in solving the injury problem
- disseminate information on the experience both nationally and internationally
- be willing to contribute to the overall network of Safe Communities.

To date, sustained community injury prevention programmes have been documented and evaluated in five New Zealand locations:

- Waitakere City (in the west of the Auckland metropolitan area)
- Waimakariri District (in North Canterbury)
- Kawerau (in the central North Island)

- Gisborne City (on the East Coast of the North Island)
- Ruatoria (also on the East Coast of the North Island).

The five NZ programmes have generally included all of the following key features:

- identification of a **single agency that takes legal and fiscal responsibility** for the programme
- establishment of an **intersectoral Advisory Group** made up of representatives from local organisations and community people with a stake in injury prevention
- establishment of one or more **Working Groups** that focus on identifying suitable activities for reducing particular kinds of injuries
- employment of one or more full or part-time programme **Co-ordinators**.

Demographic profile of New Plymouth District

New Plymouth District (NPD) is the northernmost of three territorial local authorities in the Taranaki region, situated on the west coast of the North Island of New Zealand.

Around 67,000 people currently live in NPD. This represents two percent of the New Zealand population and two-thirds of the population of the Taranaki region.

Compared with New Zealand as a whole, NPD has a relatively low proportion of young adults (aged 20-34) and a high proportion of elderly people (aged 70+).

Fifteen percent of the NPD population is Māori (a slightly lower proportion than New Zealand overall). A very low proportion of the population is Pacific or Asian, compared with the national average.

Patterns of injury in New Plymouth District

Deaths from injury

Each year, an average of 30 New Plymouth District (NPD) residents die as a result of injury.

Rates of injury deaths in NPD are around 15 percent less than New Zealand as a whole (age-standardised rates).

Two out of three injury deaths each year in the NPD are due to *unintentional* causes (19 per year).¹ The three main causes of these unintentional injury deaths are:

- motor vehicle crashes (10 per year)
- falls (3 per year)
- unspecified fractures² (2 per year).

One in three injury deaths each year in the NPD are due to *intentional* causes (10 per year). Nearly all of these intentional deaths are suicides or self-inflicted injury (9 per year).

Injury death rates (intentional and unintentional injuries combined) are highest among the oldest age group (80+) and 20-29 year olds, and lowest among 0-9 year olds.

Intentional injuries (especially suicide and self inflicted injury) cause at least half of all deaths among NPD 10-19 year olds and 40-49 year olds. In all other age groups in the NPD, *unintentional* injuries are the most common cause of death.

NPD males are over two-and-a-half times more likely than NPD females to die from injuries.

NPD Māori are just over twice as likely as NPD non-Māori to die from injuries.

Injury death rates in the New Plymouth District have been reasonably similar to the national average over the period 1989-1998.

Hospitalisations for injury

In the year 2000, 1,374 New Plymouth District residents were admitted to public hospitals for injuries.

NPD residents are around 11 percent *less* likely than all New Zealanders to be hospitalised for injuries (age-standardised rates).

In 2000, the vast majority (92 percent) of hospitalisations for injury among NPD residents were due to *unintentional* causes. Only eight percent of hospitalisations for injury were due to *intentional* causes.

In 2000, there were 1,265 hospital admissions for *unintentional* injuries among NPD residents. The most common *groups* of injuries were:

- falls (367 admissions = 29 percent)
- unspecified fractures (191 admissions = 15 percent)

¹ Injuries were classified using “E-codes” as included in the International Classification of Diseases (ICD) coding system. E-codes classify various environmental events, circumstances and conditions as “external causes” of injuries and poisonings. The 9th revision of the ICD coding system applies to both the mortality and hospitalisation data included in this report.

² These may include some fractures caused by falls.

- motor vehicle crash injuries (132 admissions = 10 percent)
- other transport injuries (83 admissions = 7 percent).

In 2000, there were 103 hospital admissions for *intentional* injuries for NPD residents. Nearly three out of four of these hospitalisations (73 percent) were for suicide and self-inflicted injury.

During the three-year period 1998-2000, 3,394 NPD residents were hospitalised for injuries. These hospitalisations were most commonly for the following six *specific* type of injuries:

- unspecified fractures (122 hospitalisations per year = 11 percent)
- falls - slipping, tripping, stumbling (114 = 10 percent)
- other falls from one level to another (88 = 8 percent)
- motor vehicle crash injuries involving drivers or passengers (68 = 6 percent)
- injuries from cutting and piercing instruments (66 = 6 percent)
- suicide attempts and self-inflicted injury (61 = 5 percent).

People from the oldest age group (80+) were by far the most likely to be hospitalised for injuries during 1998-2000. People in the middle age groups (30-69) were least likely to be hospitalised.

From 1998-2000, NPD males were 60 percent more likely to be hospitalised for injuries than NPD females (age-standardised rates). Males had higher hospitalisation rates for injury than females in all age groups except 80+.

10-19-year-olds and 20-29-year-olds were most likely to hospitalised for *intentional* injuries.

From 1998-2000, NPD Māori were 24 percent *less* likely than NPD non-Māori to be hospitalised for injuries.

Over the past 12 years, trends in hospitalisations for injuries among NPD residents have fluctuated slightly, but current age-standardised rates (2000) are nearly the same as they were in 1989. This contrasts with average New Zealand hospitalisation rates for injury, which have steadily increased since 1989.

Emergency department attendances for injury

In the year 2000, there were 6,531 attendances for injuries among NPD residents at public hospital Emergency Department clinics (EDs).

Overall, NPD males were 56 percent more likely to visit EDs for injuries than NPD females (age-standardised rates).

10-19-year-old males and females, 20-29-year-old males, and 80+-year-old females were most likely to attend EDs for injuries.

NPD Māori were 35 percent *less* likely to visit EDs for injuries compared with NPD non-Māori.

The three leading causes of injuries for which NPD people visited EDs in 2000, were:

- falls (2,290 visits = 35 percent)
- blunt trauma (1,412 = 22 percent)
- penetrating trauma (817 = 13 percent).

The most common locations where injuries occurred among NPD people who visited EDs for injury were:

- domestic situations (e.g. people's homes) (3,318 visits = 51 percent)
- sports / recreation venues (952 = 15 percent)
- public areas (634 = 10 percent)
- vehicles (614 = 9 percent)
- work (587 = 9 percent).

In 2000, males were much more likely than females to visit EDs for injuries in all locations, but the biggest differences were for injuries that occurred at work and sports / recreation venues.

ACC injury claim statistics

In the 2000 / 2001 financial year, 2,350 new entitlement claims for injuries were made to ACC in New Plymouth District.

NPD people were 12 percent more likely to make claims than New Zealanders in general.

Males were 69 percent more likely than females to apply for ACC compensation during this time (age-standardised rates).

For males, the highest claim rates were among 15-24-year olds, whereas for females, 75+-year-olds had the highest claim rates.

Children (aged 0-4 and 5-14) had by far the lowest new ACC claim rates in 2000 / 2001.

The highest numbers of claims were made for injuries that occurred:

- in home / community situations (874 claims = 37 percent)
- at work (586 = 25 percent)
- at sports / recreation venues (461 = 20 percent).

In 2000 / 2001, NPD males were far more likely than females to make claims for injuries sustained at work, and at sports / recreation venues.

Altogether, in the 2000 / 2001 financial year, over \$11 million was spent on ACC claims in New Plymouth District.

On average, each local claim cost \$4,990, which was 54 percent less than the national average of \$7,691.

Land transport crash statistics

In 2000 in New Plymouth District, 149 road crashes and 216 casualties (injuries and deaths) were reported to the Police.

NPD had slightly higher crash and casualty rates compared with similar areas as well as New Zealand as a whole (although NPD's reporting rates are likely to be higher than average).

Local crash and casualty rates were highest on urban state highways (compared with urban and rural local roads and rural state highways) and were considerably higher than those in other similar areas and the New Zealand average.

As for the rest of New Zealand, and similar areas, New Plymouth District's crash and casualty rates have been steadily declining over the past 12 years.

Of the 886 injury crashes reported to the Police in the District during 1996-2000, most involved minor injuries (71 percent). Crashes involving serious and fatal injuries were more likely to occur on rural roads than urban roads.

Over the period 1996-2000, the most frequent types of road users involved in injury crashes were:

- car / van drivers (608 = 43 percent)
- car / van passengers (142 = 25 percent)
- motorcyclists (99 = 12 percent).

From 1996-2000, there was a significantly higher percentage of motorcyclist casualties on both urban and rural roads in New Plymouth District compared with similar areas in New Zealand as a whole.

The most common types of reported injury crashes in NPD in 1996-2000 resulted from:

- crossing / turning movements
- losing control or meeting another vehicle head-on on road bends
- rear-end / obstruction situations (such as crashing into the back of a parked or slow-moving vehicle).

Poor observation and failing to give way or stop were by far the two most frequent contributing factors to injury crashes in NPD during 1996-2000.

In a survey conducted at the beginning of this year (2001), 93 percent of adults sitting in the front seats of vehicles in Taranaki were wearing seatbelts (one percent higher than the national average).

In the latest survey of back-seat passengers in Taranaki (conducted in 2000), 66 percent were found to be wearing seatbelts (10 percent less than the national average).

In the latest survey of child-restraint use (conducted in 2000), 77 percent of Taranaki children were using a restraint (two percent less than the national average).

In another 2001 survey, 95 percent of Taranaki cyclists were wearing cycle helmets (one percent higher than the national average).

The LTSA estimates that the “social cost” of injury crashes in the year 2000 in NPD was over \$44 million, the majority of which (\$28 million) was due to crashes on urban state highways.

Police statistics

The last three years of New Plymouth area Police statistics show that there are averages of 770 violent crimes and 63 sexual crimes in New Plymouth area each year. Serious assaults (average 285 per year), minor assaults (242) and other violence (174) are the most types of violent crime (these can result in *intentional* injuries).

The rates of violent and sexual crimes in the New Plymouth area are only slightly above the average for New Zealand.

Summary of injury patterns, New Plymouth District

| | |
|--|---|
| DEATHS | |
| Annual numbers (1996-1998) | 30 |
| Injury rates (overall) (1994-1998) | 41 / 100,000 |
| Unintentional injury rates (1994-1998) | 26 / 100,000 |
| Intentional injury rates (1994-1998) | 14 / 100,000 |
| Most common types of injuries (ranked) | Suicide, self-inflicted injuries Motor vehicle crashes Unspecified fractures [§] |
| HOSPITALISATIONS | |
| Annual numbers (1998-2000) | 1,131 |
| Injury rates (overall) (1998-2000) | 1,590 per 100,000 |
| Unintentional injury rates (1998-2000) | 1,490 per 100,000 |
| Intentional injury rates (1998-2000) | 129 per 100,000 |
| Most common types of injuries (ranked) | Unspecified fractures Falls Motor vehicle crashes |
| EMERGENCY DEPARTMENT ATTENDANCES | |
| Annual numbers (2000) | 6,531 |
| ED attendance rates (2000) | 10,100 / 100,000 |
| Most common types of injuries | Falls Blunt trauma Penetrating trauma |
| Most common injury locations | Domestic Sports / recreation Public area |
| ACC ENTITLEMENTS CLAIMS | |
| Annual numbers (2000 / 2001 financial year) | 2,350 |
| Claims rates (2000 / 2001 financial year) | 3,222 per 100,000 |
| Most common injury diagnoses | Soft tissue injuries Fracture / dislocations Lacerations / puncture wounds |
| Most common injury locations (ranked) | Home / community Work Sports / recreation |
| LAND TRANSPORT CRASHES | |
| Annual numbers of reported crashes (2000) | 149 |
| Annual numbers of reported casualties (2000) | 216 |
| CRIMES | |
| Annual numbers of violent crimes (2000 / 2001 financial year) | 767 |
| Annual numbers of sexual offences (2000 / 2001 financial year) | 58 |

[§] These may include some fractures caused by falls.

Summary of injury patterns, New Plymouth District, by sex

| | MALES | FEMALES |
|---|---|---|
| DEATHS | | |
| Annual numbers (1994-1998) | 21 | 9 |
| Injury rates (overall) | Over twice female rate | Less than half male rate |
| Unintentional injury rates | Twice female rate | Half male rate |
| Intentional injury rates | Nearly five times female rate | Just over a fifth of male rate |
| Most common types of injuries (ranked) | Suicide, self-inflicted injuries Motor vehicle crashes Unspecified fractures [§] | Motor vehicle crashes Unspecified fractures [§] Suicide, self-inflicted injuries |
| HOSPITALISATIONS | | |
| Annual numbers (1998-2000) | 636 | 495 |
| Injury rates (overall) | 60 percent higher than female rate | 60 percent lower than male rate |
| Unintentional injury rates | 65 percent higher than female rate | 65 percent lower than male rate |
| Intentional injury rates | 37 percent higher than female rate | 37 percent lower than male rate |
| Most common types of injuries (ranked) | Unspecified fractures [§] Cuts etc. Falls | Falls Unspecified fractures [§] |
| EMERGENCY DEPARTMENT ATTENDANCES | | |
| Annual numbers (2000) | 3,902 | 2,629 |
| ED attendance rates | 56 percent higher than female rates | 56 percent lower than male rates |
| Most common types of injuries | Falls Blunt trauma Penetrating trauma | Falls Blunt trauma Strain |
| Most common injury locations | Domestic Sports / recreation Work | Domestic Sports / recreation Public area |
| ACC ENTITLEMENTS CLAIMS | | |
| Annual numbers (2000 / 2001 financial year) | 1,396 | 954 |
| Claims rates | 69 percent higher than female rates | 69 percent lower than male rates |
| Most common injury locations (ranked) | Work Sports / recreation Home / community | Home / community Sport / recreation Work |

[§] These may include some fractures caused by falls.

Summary of injury patterns, New Plymouth District, by age groups

| | YOUNG CHILDREN (0-9) | OLDER CHILDREN AND ADOLESCENTS (10-19) | YOUNG ADULTS (20-29) | MID-AGED ADULTS (30-59) | OLDER PEOPLE (60+) |
|--|--|---|--|--|---|
| DEATHS | | | | | |
| Annual numbers (1994-1998) | 1 | 4 | 7 | 10 | 9 |
| Injury rates (overall) | Low | Medium | High | Medium | High-very high |
| Unintentional injury rates | Low | Low | High | Low-medium | High-very high |
| Intentional injury rates | Very low | High | High | Medium | Low |
| Most common types of injuries (ranked) | Motor vehicle crashes | Suicide, self-inflicted injuries Motor vehicle crashes | Motor vehicle crashes Suicide, self-inflicted injuries | Suicide, self-inflicted injuries Motor vehicle crashes | Fractures Motor vehicle crashes Falls Suicide, self-inflicted injuries |
| HOSPITALISATIONS | | | | | |
| Annual numbers (1998-2000) | 210 | 189 | 143 | 287 | 302 |
| Injury rates (overall) | Medium | Medium | Medium | Low | Medium-very high |
| Unintentional injury rates | Medium-high | Medium | Medium | Low | Medium-very high |
| Intentional injury rates | Very low | Medium | High | Medium-low | Very low |
| Most common types of injuries (ranked) | Falls Accidental poisoning Cuts etc. | Bicycle injuries Motor vehicle crashes Falls | Suicide, self inflicted injuries Cuts etc. Motor vehicle crashes | Suicide, self-inflicted injuries Motor vehicle crashes Cuts etc. | Falls Unspecified fractures |
| EMERGENCY DEPARTMENT ATTENDANCES | | | | | |
| Annual numbers (2000) | 1,019 | 1,666 | 1,175 | 1,922 | 749 |
| ED attendance rates | Medium | High | High | Medium-low | High |
| Most common types of injuries | Falls Blunt trauma | Falls Blunt trauma | Falls Blunt trauma | Falls Blunt trauma | Falls |
| Most common injury locations | Domestic | Domestic Sports / recreation | Domestic Sports / recreation | Domestic | Domestic |
| ACC ENTITLEMENTS CLAIMS | | | | | |
| Annual numbers (2000 / 2001 financial year) | Approx. 20 | Approx. 150 | Approx. 250 | Approx. 700 | Approx. 200 |
| Claims rates | Very low | High | High | Medium-high | High |
| Most common injury locations (ranked) | Home / community | Home / community Sports / recreation | Sports / recreation Home / community Work | Home / community Work | Home / community |

Summary of injury patterns, New Plymouth District, by ethnicity

| | MÄORI | NON-MÄORI |
|---|---|---|
| DEATHS | | |
| Annual numbers (1994-1998) | 6 | 24 |
| Injury rates (overall) | Over twice non-Māori rate (but note small numbers) | Just under half Māori rate |
| Most common types of injuries (ranked) | Suicide, self inflicted injuries Motor vehicle crashes | Suicide, self-inflicted injuries Motor vehicle crashes Unspecified fractures [§] |
| HOSPITALISATIONS | | |
| Annual numbers (1998-2000) | 118 | 1,013 |
| Injury rates (overall) | 24 percent lower than non-Māori rate | 24 percent higher than Māori rate |
| Most common types of injuries (ranked) | Motor vehicle crashes Cuts etc. Falls | Unspecified fractures [§] Falls |
| EMERGENCY DEPARTMENT ATTENDANCES | | |
| Annual numbers (2000) | 708 | 5,494 |
| ED attendance rates | 35 percent lower than non-Māori rate | 35 percent higher than Māori rate |
| Most common types of injuries | Fall Blunt trauma Penetrating trauma | Fall Blunt trauma Penetrating trauma |
| Most common injury locations | Domestic Sports / recreation Vehicle | Domestic Sports / recreation Public area |
| ACC ENTITLEMENTS CLAIMS | | |
| Annual numbers (2000 / 2001 financial year) | 195 | 1,887 |
| Most common injury locations (ranked) | Sport / recreation Work Home / community | Home / community Work Sport / recreation |

[§] These may include some fractures caused by falls.

Results from community consultation

Who and how we consulted

A total of 45 face-to-face consultation interviews were completed with representatives from a cross section of community organisations and agencies, and two focus groups (one of rural women and one of rangatahi).

Who was perceived to be most at risk of injury?

Children

Childhood injuries were generally seen to have been well-catered for in the New Plymouth District by previous community-based injury prevention initiatives. Nevertheless, interviewees saw a need to 'keep up the good work' given that children were considered highly vulnerable to injury by virtue of their inexperience, innate curiosity and innocence of the potential domestic and other environmental hazards around them.

Adolescents and young people

Adolescents and young people were also considered a group at high risk of injury. Key contributing factors were thought to include inexperience, experimentation, particularly with drugs and alcohol and risk-taking (especially in sports and recreational activities, e.g. skateboarding, surfing and cycling, as well as driving recklessly and fast). Young Māori male unlicensed drivers were also seen as a high-risk injury group.

The risk of completed suicide in young people was considered to be relatively low and therefore not a priority to target. However, several interviewees regarded the apparent rising incidence of 'hoon-like' driving behaviour, drunkenness and drug and alcohol intoxication to be a sign that all was not well with the District's youth.

Older people

Older people were identified as a 'number one' priority in terms of future community-based injury prevention approaches. Interviewees perceived the older generation as largely overlooked in terms of past community injury prevention and health promotion initiatives. The economic and personal costs of fractures in older people, particularly fractured hips in older women, were estimated to be very high and could only worsen given the projected increase in the older population over the next 40 years.

Māori

In general, Māori injury rates were perceived to be similar to non-Māori. However, some differences were noted in the prevalence of certain types of injuries and injury risk factors. Māori were considered to be at high risk of road-related, sports and industry-related injuries (especially in industries involving a high level of manual labour).

People participating in sport or recreation

Sports were perceived to be a major cause of injury. Interviewees identified a range of sporting codes and recreational activities that they perceived as high-risk. These ranged from the higher level contact sports such as rugby, rugby league, netball, basketball, and touch rugby, to the individual level sports and recreational activities such as cycling, skiing, road cycling and skateboarding. Mountain biking was described as an 'extreme sport' with a very high injury risk among its participants.

Interviewees identified a range of causative factors influencing sports injuries including:

- failure to wear suitable protective gear
- faulty equipment
- poor judgement and limited experience
- children playing sport beyond their developmental level
- coaches failing to train with safety in mind

- individuals failing to take responsibility for their own safety.

People in the workplace

The workplace was seen as one of the more potentially fruitful sites for transferring safety and injury prevention skills.

Health and safety personnel and managers from the oil, port transport and timber industries considered that all three of these industries currently have high quality safety programmes in place. In the past, these three industries apparently had a reputation for high numbers of injuries among workers (mainly back injuries and amputations). However, in recent years there appears to have been a dramatic decrease in workplace injuries in these industries, with company health and safety programmes reported to be largely responsible for this.

People on farms

A large number of interviewees believed farming families, particularly adult male farmers and children aged two to nine years, faced a relatively higher risk of injury compared to their urban counterparts. They attributed this risk to the nature of the work undertaken by farmers, which exposed them literally on a daily basis to working with unpredictable stock, with heavy machinery and potentially dangerous equipment, and to an environment where bad weather can see them “up to the eyes in mud”.

The potential for injuries in farming children was perceived as influenced by similar factors impacting on and experienced by their parents. However, children’s ‘ignorance’ and innocence of the potential dangers in their day-to-day environment was seen to pose additional risks that urban children were rarely exposed to. These dangers included:

- unfenced swimming pools and water holes
- being run over by large machinery
- under-age driving of all terrain vehicles (ATVs) and tractors
- being left at home unsupervised (in legal terms).

People at home

The home was perceived to be the most common place where injuries occur, not just for children, but for all other population groups as well (ie. young people, adult men and women, and older people).

People on the roads

Injuries and deaths from motor vehicle crashes were reported to have ‘drastically reduced’ over the past decade, both nationally and in the New Plymouth District.

The groups perceived to remain at highest risk of death and injury from vehicle crashes were:

- children, especially cyclists
- young people, particularly young Māori males without a driver licence
- older people (car crashes and mobility scooters).

Suggested interventions

Participants in the consultation favoured various specific interventions to reduce the risk of different injuries in different population groups. These are discussed in detail in Chapter Six of this report.

Cross sector approaches to community injury prevention

Interviewees were generally enthusiastic supporters of the community-based intersectoral approach to injury prevention. Most saw this approach as the ‘only way to go’, as no one organisation or strategy was considered likely to succeed on its own.

Many interviewees pointed to ‘successful’ inter-agency initiatives already operating in the district to reduce injuries, such as Road Safety Taranaki, Plunket and the Kidsafe Trust. Interviewees also commended the industrial health and safety initiatives that have been developed through collaborative partnerships between ACC, OSH and the relevant industries involved.

Sectors and groups interested in community-based injury prevention

Groups that have already played a major role in developing injury prevention initiatives, such as Health Promotion Unit (Taranaki Health), New Plymouth District Council, Tui Ora, Kidsafe Taranaki, Plunket, the Police, Road Safe Taranaki and the ACC, indicated their continuing interest and desire for involvement in injury prevention in the district.

As well, several interviewees whose organisation had either been less involved or not involved at all in previous community-based injury prevention initiatives signalled their organisation’s interest and willingness to be involved in future initiatives. These organisations included:

- The Fire Service
- St Johns Officers and the Ambulance Service
- Te Puni Kokiri
- WestpacTrust Sport Taranaki
- Rural women’s groups

- The Pinnacle Independent Practitioners Association.

Other identified potential partners in the development of intersectoral, community-based injury prevention strategies included the Strengthening Families initiative and the Safer Community Council's focus groups.

Guiding principles for developing a community injury prevention programme

Other studies offer a range of advice and recommendations relating to the design and running of community injury prevention programmes. Key points made in these studies include:

- functions and responsibilities of the members of a programme's Advisory Group should be carefully and clearly defined
- Advisory Group members should have an understanding of, and commitment to, injury prevention using community development approaches
- in the early stages, it is important to undertake some kind of planning or consultation process to produce a community profile or needs assessment
- programmes that are well supported by local authorities (ie. city or district councils) are most likely to do well
- the co-ordinator role is pivotal to the success of community injury prevention. Programmes should employ at least one full or part-time paid co-ordinator. Relying on voluntary labour alone is not sufficient
- co-ordinators should have access, as a matter of course, to secretarial services and other support services and amenities to sustain their work
- there is really no set formula for easily working out which kinds of injury prevention activities a community injury prevention programme should adopt. The people involved need to weigh up many different factors when deciding which activities to choose.
- the philosophy, goals and strategies of the programme should be compatible with the prevailing values or beliefs of the target community
- the capacity of members of community and volunteer groups, as well as members of the general public, to participate in the work of designing and implementing community injury prevention activities can be highly variable. It can be particularly difficult to achieve a high degree of participation in disadvantaged communities, where a high proportion of people may be experiencing adversity in their lives.

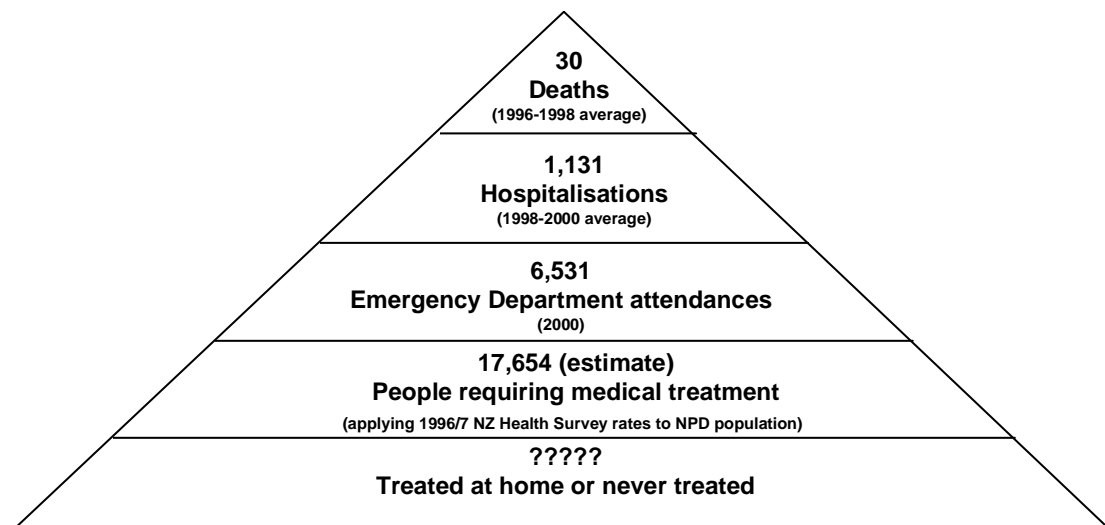
- injury prevention programmes designed for Māori should adopt a holistic perspective; consider Māori perspectives and values; be delivered by Māori for Māori; facilitate Māori workforce development; and facilitate positive development of whanau wellbeing
- injury prevention programmes are likely to work best if the participating people and organisations are compatible with one another in terms of their overall philosophy, goals and social outlook
- developing a shared vision for the programme can be important for helping to avoiding situations where some participants end up becoming “passengers”, rather than active contributors to the programme
- co-ordinating structures and decision-making processes should be kept as simple as possible
- relationships between participants in a community injury prevention programme should be characterised by trust and respect
- a community injury prevention programme needs to be given sufficient time to properly evolve, bed-in and mature
- if resources are available to evaluate injury prevention programmes, the evaluation should not dominate the programme itself
- in programme evaluations, it is often more appropriate to monitor intermediate outcomes (like changes in safety behaviour and awareness among members of the public) rather than injury incidence surveillance outcomes (like deaths, ED visits) This is because of the lack of availability of suitable surveillance data and the difficulties in causally linking these types of outcomes with the effects of the programme.

Establishing a community injury prevention programme in New Plymouth District

The challenge for the Injury Safe Advisory Group is to plan a suitable injury prevention programme for the local community, using the information in this report, together with the Group’s own knowledge of the local situation and possibly further consultation with the community.

It is clear from the available statistics and the community consultation that New Plymouth District does have a problem with injuries, as summarised in the injury pyramid below:

INJURY PYRAMID FOR NEW PLYMOUTH DISTRICT - ANNUAL NUMBERS OF INJURIES



An intersectoral community injury prevention programme, based on the WHO Safe Communities model, appears to have the potential to help reduce the number and severity of these injuries.

Research suggests that there are two key pre-requisites for developing a successful community injury prevention programme:

- (1) key members of the community must accept there is a need for a programme and support its introduction.
- (2) there must be sufficient capacity and resources in the community to run the programme, including input from partner organisations and the wider general public.

There are favourable signs that New Plymouth District Injury Safe programme already meets these two pre-requisites.

There are also three important steps that a community injury prevention programme should aim to take early in its development to increase the likelihood that it will be successful.

(1) *identify priorities and strategies for action.* The community consultation undertaken for the needs assessment for the New Plymouth Injury Safe programme has already identified the following population groups as possible priorities:

- older people
- children
- adolescents and young people
- Māori

- people on farms
- people participating in sports and recreation
- people in the workplace
- people at home
- people on the roads.

(2) *develop a comprehensive programme plan* that includes descriptions of the following:

- the programme's mission, goals, objectives, targets
- specific activities, strategies, interventions planned to address priorities
- organisational structure (including a paid co-ordinator, and possibly working groups)
- clearly defined partner relationships.

(3) *plan for some degree of monitoring and evaluation* of the programme.