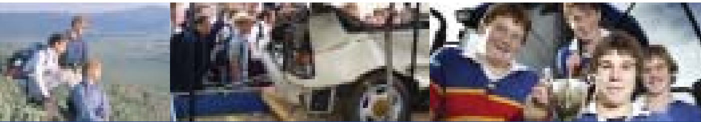
NPiS
New Plymouth injurySafe



SUMMARY OF REPORT

NEW PLYMOUTH DISTRICT

Community Injury Prevention Needs Assessment

Prepared for New Plymouth injurySafe
September 2006

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Disclaimer

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List of Acronyms

ACC	Accident Compensation Corporation
ASR	Age-standardised rate
ATV	All terrain vehicle
CYF, CYFS	Child, Youth and Family Service
DHB	District Health Board
DOL	Department of Labour
ED	Emergency Department
GP	General practitioner
HPU	Health Promotion Unit (of the Taranaki District Health Board)
HSE Centre	Health Safety and Environment Centre
ICD	International Classification of Diseases
NPD	New Plymouth District
NPDC	New Plymouth District Council
NPiS	New Plymouth injurySafe
NZDep2001	New Zealand deprivation index, 2001
NZHIS	New Zealand Health Information Service
NZIPS	New Zealand Injury Prevention Strategy
NZQA	New Zealand Qualifications Authority
PHO	Primary Health Organisation
SCFNZ	Safe Communities Foundation New Zealand
SHORE	Centre for Social and Health Outcomes Research and Evaluation (Massey University)
SPARC	Sport & Recreation New Zealand
TCP	Thinksafe Community Projects
TLA	Territorial Local Authority
TMG	Te Rito Management Group
WHO	World Health Organization
WISE	Waitara Initiatives Supporting Employment

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Report Summary

This report presents the results of the 2006 New Plymouth District community injury prevention needs assessment.

The assessment was commissioned by the Taranaki District Health Board Health Promotion Unit for New Plymouth injurySafe (NPiS) and undertaken by Research and Evaluation Services Ltd (New Plymouth) in association with HealthSearch Ltd (Auckland).

The main aim of the needs assessment was to compile relevant statistical and qualitative information to identify patterns of injury in New Plymouth District. This information will be used by NPiS to:

- help monitor progress in reducing the incidence and severity of injury in the District
- identify future injury prevention priorities and strategies for addressing them.

Information for the needs assessment was obtained in three main ways:

- analysing injury data from local and national statistical collections, including mortality, hospitalisation, emergency department, injury insurance claim (ACC) and road crash injury data
- consulting with key people and organisations in New Plymouth District with an interest in injury and injury prevention
- reviewing published reports and other literature examining the development of New Plymouth injurySafe and other recent New Zealand injury prevention initiatives.

DEVELOPMENT OF NEW PLYMOUTH INJURYSAFE

New Plymouth injurySafe (NPiS) is a coalition of people with links to a wide range of New Plymouth District organisations, businesses and groups with an interest in injury prevention and community safety. The origins of NPiS can be traced back to early 2001, when personnel from five local agencies (Tui Ora Ltd, the Kidsafe Taranaki Trust, the community development section of New Plymouth District Council, the Health Promotion Unit of Taranaki Health, and Plunket) agreed to meet together on a regular basis to try to better align and co-ordinate their injury prevention priorities and activities. Later that year, with funding support from ACC, the group commissioned the first New Plymouth District community injury prevention needs assessment. This involved the analysis of local and national injury statistics and extensive consultation with a range of local organisations and individuals with an interest in injury prevention. Out of this work, five priority issues for future intersectoral action in the district were identified:

- Falls among older people
- Children's falls
- Youth, in relation to roads and violence
- Injuries to Mäori
- Farm injuries.

ACCREDITATION AS A WHO SAFE COMMUNITY

Early in 2005, NPiS and the New Plymouth District Council formally agreed to work together to apply for New Plymouth District to become officially accredited as a World Health Organisation (WHO) Safe Community. Criteria for becoming an accredited Safe Community of the WHO Safe Community Network include having an infrastructure governed by a

The plan expressed the commitment of the NPiS partners and participating organisations to continue to work collaboratively towards a shared vision of New Plymouth District becoming a safe community without the burden of injury.

cross-sectoral group and running long-term sustainable injury prevention programmes that cover both genders, all ages and all environments and situations.

Following preparation and submission of an extensive application document, a site visit by WHO representatives was conducted in New Plymouth on 12 and 13 September 2005. Just over one month later, on 27 October 2005, the New Plymouth District was designated the 95th WHO Safe Community.

STRATEGIC PLANNING AND DEVELOPMENT

In 2005 NPiS developed a three-year Strategic Plan. The plan expressed the commitment of the NPiS partners and participating organisations to continue to work collaboratively towards a shared vision of New Plymouth District becoming a safe community without the burden of injury. An annual implementation plan for 2005-2006 was also developed at this time. This indicated more precisely the strategies, indicators and measures to be used during that financial year to achieve the NPiS objectives.

Currently the core partners of NPiS are Tui Ora Ltd, the Health Promotion Unit of the Taranaki District Health Board, the New Plymouth District Council, Kidsafe Taranaki Trust, ACC and the New Plymouth Police. NPiS's current intersectoral network includes 24 organisations whose interest areas cover children, young people and older people's health and wellbeing, sport and recreation, industry including farming, and road safety. Recently, NPiS has obtained funding for a programme manager.

NEW ZEALAND INJURY PREVENTION STRATEGY (NZIPS)

Looking at the wider New Zealand context now, a key development in 2003 was the release in June of the New Zealand Injury Prevention Strategy (NZIPS). Developed by a consortium of representatives from government and non-government agencies, led by ACC, the strategy aims to provide a consistent national framework and guide for action for policy development and service delivery. This is expected to encourage more effective use of resources and the development of better focused injury prevention efforts (Dyson 2003).

In October 2003 an Implementation Plan for the strategy was officially launched (Dyson 2003a). This identified specific work items to be undertaken by government agencies in support of the strategy during the financial year 1 July 2004 – 30 June 2005.

In July 2005, a new Implementation Plan was released for the strategy covering the three years 1 July 2005 – 30 June 2008.

LOCAL GOVERNMENT ACT 2002

Another noteworthy development at the national level has been changes to local government legislation. These have enhanced and broadened the responsibility of local territorial authorities and regional councils for health and safety issues in their

communities (Department of Internal Affairs 2005; New Zealand Injury Prevention Strategy nd).

In 2002, the Local Government Act 1974 was revised, and the new Act defined the purpose of local government as being:

(a) to enable democratic local decision-making and action by, and on behalf of, communities; and

(b) to promote the social, economic, environmental, and cultural well-being of communities, in the present and for the future (Part 2, section 10 of the Local Government Act 2002).

This legislative change applies to one of the core partners of NPiS – the New Plymouth District Council, and has implications for the broad role it may be able to have in local injury prevention initiatives.

WORKING INTERSECTORALLY

The previous New Plymouth District injury prevention needs assessment report reviewed literature from New Zealand and overseas about how to work in effective ways across different sectors, particularly with regard to community injury prevention (McClellan et al. 2001).

Since then, a considerable amount of new literature has been published on working intersectorally. This includes several New Zealand publications that have examined success factors and presented a number of local case studies of community initiatives, for example:

- A Meta-analysis of Community Action Projects: Volumes I and II (Greenaway et al. 2004, 2004a)
- 'Headline' Local Partnerships in Aotearoa / New Zealand (Larner and Butler 2003)
- New Zealand Intersectoral Initiatives for Improving the Health of Local Communities: An Updated Literature Review Examining the Ingredients for Success (Ministry of Health 2005)
- Mosaics – Whakaahua Papariki: Key Findings and Good Practice Guide for Regional Co-ordination and Integrated Service Delivery (Ministry of Social Development 2003).

There is general agreement in the literature that working intersectorally is justified when sectors working together in a group can achieve better and more sustainable outcomes than a single sector working on its own. This is usually for issues where the determinants / influences on the well-being of populations and communities are diverse, complex and multifactorial (Lasker and Weiss 2003; Ministry of Health 2005). Injury prevention can be considered to be this type of issue.

SOCIAL PROFILE OF NEW PLYMOUTH DISTRICT

The New Plymouth District is situated on the west coast of the North Island of New Zealand. It is the northernmost of the three Territorial Local Authorities (TLAs) in the Taranaki region, the others being Stratford District and South Taranaki District.

In 2001 a total of 66,603 people were usually resident in New Plymouth District. This was 65 percent of the Taranaki population (103,026).

Compared to the whole New Zealand population, the New Plymouth District (NPD) has a higher proportion of older people and a lower proportion of working age adults.

In 2001, Mäori comprised 13 percent of the New Plymouth District population.

Almost three-quarters (72 percent) of the population of the New Plymouth District live in the urban and suburban areas of New Plymouth itself.

DEATHS FROM INJURY

On average each year, almost 30 NPD residents die as a result of injury.

About two-thirds of injury deaths among New Plymouth District residents are due to unintentional causes, with most of the remainder due to intentional causes.

In 2000-2003, most of the deaths due to unintentional injuries involved:

- transport accidents (8 per year)
- falls (6 per year)
- drowning / submersion (1 per year)
- accidental poisoning (1 per year).

The vast majority (85 percent) of deaths due to intentional injury were caused by intentional self-harm - suicide and other types of self-inflicted injury (7 per year).

In the four year period 2000-2003, the average annual age-standardised death rate for injury among New Plymouth District residents was slightly higher than that of New Zealand as a whole.

Injury death rates in NPD were highest in the oldest age group (80+) and lowest among 0-9 year-olds. Another (lower) peak in rates occurred for 20-29 year olds.

Intentional injuries (predominantly suicide and other self-inflicted injuries) contributed to nearly half of all injury deaths among 20-29 year olds, 30-39 year olds and 40-49 year olds. This contrasts with the pattern for all other age groups where unintentional causes were far more common than intentional causes.

The age-standardised injury death rate for males living in the New Plymouth District was just over double the female rate.

The age-standardised rate of injury deaths among Mäori was nearly twice that of non-Mäori.

People living in the most socio-economically deprived areas of NPD had higher injury death rates than people living in less deprived areas.

Trends in injury-related death rates in NPD are quite difficult to analyse because of small numbers and a change in classification systems in 2000. However, looking at longer term trends over the period 1989-2003, injury mortality rates in NPD appeared to be below the national average during the early 1990s, but were very similar to the national average in the mid 1990s. In the late 1990s, the NPD rates again were slightly below that of New Zealand as a whole. From 2000-2003, NPD rates were initially higher, then became lower than the national rates.

HOSPITALISATIONS FOR INJURY

In the five year period 2001-2005 an average of 1364 NPD residents per annum were admitted to hospital due to injuries (includes both intentional and unintentional). Over this same period, 87 percent of these admissions were for unintentional injuries and just 8 percent of admissions were due to intentional injuries.

The most common groups of injuries were:

- falls (42 percent)
- exposure to inanimate mechanical forces (15 percent)
- transport-related accidents (14 percent).

Overall the male hospitalisation rate for injury was 1.6 times that for females. Males had higher hospitalisation rates than females in all age groups except the 70-79 and 80+ age groups.

On an age-adjusted basis, Mäori and non-Mäori in NPD had an almost equal chance of being hospitalised due to injury.

In all age groups, people living in the most socio-economically deprived areas of NPD were more likely to be hospitalised for injury than people living in less deprived areas.

From 1989 until 1997 the rates of hospitalisation for injury in NPD were higher than for New Zealand as a whole. However, in 1998 the trend reversed and in recent years NPD has had an injury hospitalisation rate somewhat lower than New Zealand as a whole.

EMERGENCY DEPARTMENT ATTENDANCES FOR INJURY

In the year 2005, there were 7253 Emergency Department clinic (ED) attendances for injuries among NPD residents.

The ED attendance injury rate for males was 72 percent higher than for females (age-standardised rates).

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

The non-Mäori age-standardised rate of ED attendance was slightly higher than the rate for Mäori.

The three leading causes of injuries for which NPD residents attended EDs in 2005 were:

- falls (32 percent of all attendances)
- blunt trauma (30 percent)
- penetrating trauma (10 percent).

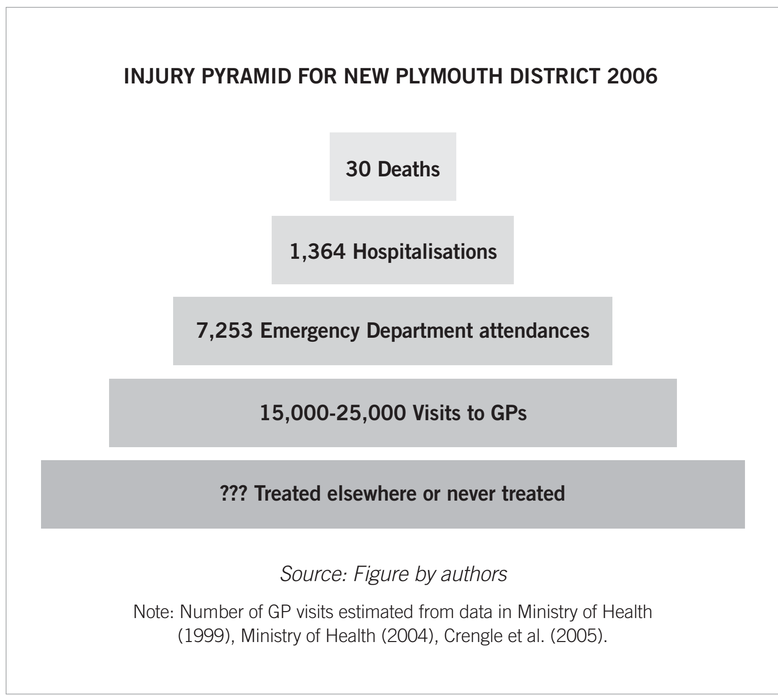
People living in the most socio-economically deprived parts of New Plymouth District were much more likely to attend public hospital EDs for injury than those living in less deprived areas.

The three most common sites where injuries occurred among NPD residents who attended ED were:

- domestic situations (48 percent)
- sports / recreation venues (14 percent)
- workplaces (12 percent).

ACC INJURY CLAIM STATISTICS

In the 2005 / 2006 financial year in NPD, a total of 2167 new entitlement claims were recorded by ACC.



Source: Figure by authors

Note: Number of GP visits estimated from data in Ministry of Health (1999), Ministry of Health (2004), Crengle et al. (2005).

The NPD ACC new claim rate was slightly higher than the New Zealand average.

NPD males were twice as likely as NPD females to have ACC new claims over the 2005 / 2006 period.

For males, the highest claim rates were among 20-29 year-olds. For females, 50-59 and 65+ year-olds had the highest claim rates.

Children aged 0-9 years had by far the lowest claim rates.

Eighty-three percent of NPD claimants were European / Pakeha, 10 percent were Mäori and 4 percent were of other ethnicities.

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

- in home / other domestic situations – 37 percent (compared to 30 percent for NZ as a whole)
- at local sports / recreation venues – 18 percent (compared to 15 percent for NZ as a whole).

In 2005/ 2006 males were more likely than females to make claims for injuries sustained on farms, at industrial places and at sports / recreation venues; whereas females were more likely to claim for injuries that occurred in the home.

In the 2005 / 2006 financial year, over $10 million was spent on ACC new entitlement claims in New Plymouth District. On average, each claim cost $4,770. This was slightly less than the national average of $4,993.

ROAD TRAFFIC CRASH STATISTICS

In the 10 years from 1996-2005, a total of 1823 road traffic crashes in NPD involving injury were reported to the Police. A total of 2622 people were injured in these crashes.

From 1999 through to 2002 the total number of serious or fatal road traffic crashes that occurred in NPD moved progressively downwards, before spiking markedly up again in 2003 and 2004. However, in 2005 the total fell to 26, the lowest recorded in the 10-year period.

In 2001-2005 a total of 195 fatal or serious crashes were reported in NPD, compared to 259 in 1996-2000.

Most crashes involving injury in NPD occurred on urban roads. However, crashes that occurred on rural roads more often involved serious and fatal injuries.

Of the 2622 traffic casualties in NPD between 1996 and 2005, just over half (51 percent) were drivers of cars or vans, while slightly less than a quarter (24 percent) were passengers in cars or vans.

Twenty-three percent of all road crash casualties in New Plymouth District were aged 15-19. The other leading casualty groups were 20-24 year olds and 25-29 year olds. Altogether, 42 percent of all road crash casualties were aged between 15 and 29.

The most common types of vehicle movements involved in urban road injury crashes were:

- crossing / turning movements
- rear end / obstructions
- loss of control / or head on collisions on road bends.

On rural roads the most common types of vehicle movements involved in urban road injury crashes resulted from:

- loss of control / or head on collisions on road bends
- crossing / turning movements
- loss of control / or head on collisions on straight roads.

Poor observation and failure to give way or stop were the two most common contributing factors to injury crashes on urban roads in the New Plymouth District. On rural roads, poor observation was the most common factor contributing to injury crashes followed by poor vehicle handling.

Intersections are a common site for injury crashes in the New Plymouth District, more so than the rest of New Zealand.

The proportion of crashes involving alcohol was lower in NPD compared to New Zealand as a whole.

The most recent surveys show the rate of front seat belt use, rear seat belt use and child restraint use is higher in NPD compared to New Zealand as a whole. Cycle helmet use was also slightly higher than it was for all New Zealand.

POLICE STATISTICS

In 2005, violent and sexual offences together contributed to 20 percent of all recorded offences in New Plymouth Policing Area, compared to 13 percent of all recorded offences nationally.

From 1996 to 2005, the annual numbers of recorded violent offences in NPD increased by 42 percent (from 627 to 890). A similar trend was evident for New Zealand as a whole.

The total numbers of recorded sexual offences were similar in NPD in 1996 (70) and in 2005 (75).

CORONER'S SUICIDE DATA

Over the ten-year period 1996-2005, 93 suicides were investigated by the local coroner. Eighty percent of these suicides were by males. The most common ages for committing suicide were 30-39 (contributing to 27 percent of suicides) and 20-29 (20 percent). The most common suicide methods were hanging (42 percent) and carbon monoxide poisoning (26 percent).

Results from the community consultation

The consultation process identified eight priority groups for future injury prevention work in NPD.

The groups, ranked according to how frequently consultation participants nominated them as being the most important, were:

1. Road users (nominated by 14 people)
2. Older people / kaumätua – mainly falls (11)
3. Intentional injuries – domestic violence, suicide, assaults (8)
4. Young people / rangatahi (7)
5. Children / tamariki – mainly poisonings and falls (7)
6. People in the workplace (6)
7. Mäori (6)
8. People participating in sport or recreational activities (1).

ROAD USERS

The consultation suggested that efforts to reduce road crashes 'should stay up there' despite the district's reducing road toll. Key reasons for maintaining road user injuries as an injury prevention priority included the high long-term impact and cost of these injuries at a societal, economic and personal level, and the fact that so many road crashes are preventable. Road injury groups perceived to be most at risk of death and injury on roads were:

- children
- young drivers
- older drivers
- truck drivers
- pedestrians.

OLDER PEOPLE/ KAUMÄTUA

Falls, bumps at home, sprains / strains during veteran sports and elder abuse were identified as being common injuries among older people in the community. There was considerable optimism and praise for the work that had been done in the district over the past five years in terms of setting up sound injury prevention interventions for older people. However, the general perception was that demand for the Tai Chi programme was outstripping the supply of suitably qualified tutors. The high public health and personal costs resulting from injuries among older people and the ageing of the country's population were the two main reasons given for ranking older people / kaumätua so highly as a priority.

INTENTIONAL INJURIES

Suicides, attempted suicides, domestic violence (including child, parent and elder abuse) and violent assaults were among the most frequently identified forms of intentional injuries. Several programmes and services were said to exist in the district to help victims of intentional injuries and violence. Some optimism was expressed about the forthcoming Te Rito family violence prevention public awareness campaign. However, others saw this as likely to create a demand for already stretched services. Others saw the whole intentional injury prevention area as possibly in the 'too hard basket.' Two participants saw a need to implement the New Zealand Suicide Prevention Strategy.

YOUNG PEOPLE / RANGATAHI

Injuries resulting from sport and recreational activity, falls, vehicle crashes and assaults (and to a lesser degree sexual assaults) were among the more commonly identified injuries that occurred in the 15-25 year age group. Alcohol and drug use, including the use of party pills, were seen to underpin a large proportion of the assaults and road crash injuries in the younger age group. Many consultation participants saw the alcohol and drug abuse phenomena among young people as largely a consequence of poor parenting, particularly the failure of parents to set and maintain boundaries for their offspring.

CHILDREN / TAMARIKI

Poisonings, cuts, fractures, bruises, burns and scalds were identified as common children's injuries. There was general consensus among participants working directly in the area of promoting child health that current interventions appear to be working, evidenced by a slight decrease in children's admissions to hospital. However, most of these same participants saw 'no room for complacency.' Some expressed concern about what they saw as a fall off in child car seat compliance. Most children's injuries were said to occur in the home and in schools. Child pedestrians were seen as another high-risk injury group. Safety around school crossings was an important issue for the child-focused participants. Reduction and enforcement of speed limits and improvement of road signage around school crossings and schools in general were seen as possibly the most effective intervention for preventing school-aged children's injuries.
Injury prevention interventions at an intermediate school level were seen as a current injury prevention gap.

PEOPLE IN THE WORKPLACE

Types of workers identified as priorities for future injury prevention included: young manual workers, older workers, migrant workers, shift workers (including truck drivers) and farming families. The bigger energy, construction and transportation companies in the New Plymouth District (and the wider Taranaki region) were generally congratulated for successfully reducing their workplace injuries. This success was attributed to having established robust health and safety monitoring systems, good training programmes, and generally promoting a workplace safety culture designed to reach beyond the workplace gates. However, there was seen to be some way to go in terms of reducing hazards and injuries in some of the district's medium and small sized companies. The recent opening of the award winning, inter-agency sponsored Health Safety and Environment Centre in New Plymouth was considered a 'ground-breaking achievement' and one that several other districts were reportedly seeking to emulate.

MÄORI

In general, injury patterns among Mäori were considered similar to those for non-Mäori. However, there was some suggestion that many of the injuries sustained by Mäori are more serious. Mäori were also seen as a population with higher health needs. Tamariki (falls, burns and scalds and poisonings), rangatahi (vehicle crashes, assaults and sports and recreation injuries) and kaumätua (falls) were all considered priority groups within the Mäori population. Two participants with specific knowledge of injuries impacting on Mäori considered there were important barriers to Mäori accessing treatment for injuries, which required consideration and specific interventions. Evidence indicated clear differences between Mäori and non-Mäori in terms of ACC entitlement claims, with Mäori proportionately making fewer claims compared to non-Mäori.

SPORTS AND RECREATION PARTICIPANTS

Taranaki's population generally was seen as one of the more physically active in New Zealand. However, this higher level of participation in physical activity also brought with it a higher risk of injury. Consultation participants identified a number of factors possibly contributing to NPD's 'high level' of sports and recreational injuries. These included the increasing number of veterans continuing to participate in sports and recreational activities, high levels of participation in extreme sports such as mountaineering, surfing and mountain biking, poor technique and use of sub-standard equipment.

Summary of Evidence for Identified Priorities

1. ROAD USERS / TRAFFIC CRASHES

STATISTICAL ANALYSIS

Deaths

- Most common cause of unintentional injury death
- 32 deaths over 4 years 2000-2003 (average 8 per year)
- Most common cause of death for 10-19, 50-59, 60-69 and 70-79 year olds
- Most common cause of injury death for males, second most common for females
- Those killed usually are car occupants

Hospitalisations

- Third most common cause of injury hospitalisations,
- 948 hospitalisations over 5 years 2001-2005 (average 190 per year)
- ASRs 286 per 100,000 for New Plymouth District compared with 330 per 100,000 for New Zealand over 5 years 2001-2005
- Road users most commonly hospitalised = car occupants, pedal cyclists and motorcyclists
- Age groups most likely to be hospitalised = 10-19, 80+ and 20-29 year olds

Emergency Department attendances

- 654 attendances in 2005 for injuries that occurred in vehicles (10% of all injury related attendances)
- ASRs: 937 per 100,000 for males compared with 536 per 100,000 for females
- Age-specific rates highest in 10-19 and 20-29 year olds

ACC claims

- 95 new claims in 2005 / 06 were for motor vehicle injuries (4% of all new claims for that year)
- 62% of new motor vehicle-related claims were for car drivers or passengers and 18% were for motorcyclists

Road crashes

- 248 reported road crash casualties in NPD in 2005, including 7 fatal, 28 serious and 213 minor
- NPD injury crash rate = 26 per 10,000 population in 2005, same as NZ rate
- 54% of NPD injury crashes were on urban roads and 46% were on rural roads (2001-2005)
- Poor observation contributing factor in 50% of urban crashes and 30% of rural crashes
- In NPD, intersections more common site for injury crashes than in NZ as a whole

COMMUNITY CONSULTATION

Population groups and types of injuries

- All – drink driving, fatigue, lack of defensive driving
- Children – car restraints, speeding near schools
- Young people – inexperience, unlicensed driving, unwarranted cars, speed, drugs, alcohol
- Older people – medical factors
- Truck drivers – fatigue, large vehicles, road design, ageing workforce
- Pedestrians – walking on road at night

Existing interventions

- Car restraint surveillance and Safe To Go car seat training (Kidsafe, Police)
- National road safety awareness campaigns (Land Transport New Zealand, Police)
- ThinkSafe (ACC)
- Speed enforcement surveillance (Police)
- THINKsmart sports clubs accreditation (intersectoral)
- Mokau driver fatigue initiative (ACC, Police, local community)
- Mobile speed trailer (ACC, Police)
- DrinkSafe 4 Youth (Police)
- Students Against Drunk Driving
- Alco-link
- Land Transport New Zealand's work with trucking companies

Suggested interventions

- Increase focus of Kidsafe on road safety promotion for children
- Driver education by Land Transport New Zealand and ACC on handling icy and adverse road conditions
- Maintenance of Police's current focus on speed, especially near schools
- Reinstate Land Transport New Zealand's Waitara young drivers' licensing programme
- Breathalysers in pubs, clubs, bars
- Freshen up road safety messages and TV advertising

EXISTING PRIORITIES

NPiS Priorities

Short-term: 2002-2004

- Mäori road
- Youth road

NZIPS Priorities

- Motor vehicle traffic crashes is 1 of the 6 national injury prevention priority areas

2. OLDER PEOPLE / KAUMÄTUA (65+)

STATISTICAL ANALYSIS

Deaths

- 80+ year olds have by far the highest mortality rates for injury (264 per 100,000 in 2000-2003)
- Transport accidents the most common cause of injury death in 60-69 and 70-79 year olds
- Falls and transport accidents the most common causes of injury death in 80+ group

Hospitalisations

- 80+ year olds have by far the highest injury hospitalisation rates (9855 per 100,000 in 2001-2005)
- Falls are by far the most common cause of injury hospitalisation in the 60-69, 70-79, and 80+ groups, for both males and females
- Transport accidents and exposure to inanimate mechanical forces are next most common causes
- Compared with NZ, New Plymouth District residents aged 60-69, 70-79, 80+ now have lower hospitalisation rates for injury

Emergency Department attendances

- 80+ group had third highest attendance rate for injury in 2005 (after 10-19 and 20-29 year olds)
- Attendance rates in 60+ group were by far the highest for falls, followed by blunt trauma
- Attendance rates in 60+ group were by far the highest for injuries occurring in domestic situations

ACC claims

- In 2005 / 06 rates of ACC new claims for 60-64 and 65+ groups were lower than 20-29, 40-49 and 50-59 year olds but higher than the other age groups

Road crashes

- People aged 60+ accounted for 14% of crash casualties in 2001-2005

Coroner suicide data

- Number of suicides among 60-69 and 70-79 year olds was lower than in all other age groups (1996 to 2005)

COMMUNITY CONSULTATION

Population groups and types of injuries

- Fractures (especially hip) – from slips, trips and falls
- Bruises and grazes – from bumping against home fittings and furniture
- Sprains and strains – veteran sports and physical activities
- Elder abuse – physical, emotional and financial abuse and neglect

Existing interventions

Direct

- Otago Exercise Programme (NZ Falls Prevention Research Group, ACC, Taranaki DHB)
- Tai Chi (ACC)
- Base Hospital physiotherapists and occupational therapists follow-up home visits after hospitalisation
- Waitara Home Safety programme (ACC, Fire Service, Housing NZ, Ministry of Social Development)

Indirect

- Green Prescription (SPARC)
- Push Play (SPARC)
- Aqua jogging, 50 Forwards (Sport Taranaki, PHOs)
- Active in Age (Arthritis Foundation)
- Marae-based kaumätua exercise and kapa haka

Suggested interventions

- Directory of programmes and services catering for older people
- 'Train the trainer' programmes for Tai Chi
- PHO co-ordinators to follow-up after hospitalisations including assessment of home, medication, nutrition

EXISTING PRIORITIES

NPiS Priorities

Short-term: 2002-2004

- Older people falls

NZIPS Priorities

- Falls is 1 of the 6 national injury prevention priority areas

3. INTENTIONAL INJURIES

STATISTICAL ANALYSIS	COMMUNITY CONSULTATION	EXISTING PRIORITIES
Deaths • 33 deaths over 4 years 2000-2003 (average 8 per year, 28% of all injury-related deaths) Age-standardised rate = 12 per 100,000 • Most common causes = intentional self-harm (28 over 4 years 2000-2003), assault (5) • Intentional self-harm is the most common cause of injury-related death for 20-29, 30-39 and 40-49 year olds • Intentional self-harm is the 2nd most common cause of injury-related death for males and the 3rd most common cause for females • Intentional self-harm is the most common cause of injury-related death among Mäori and the second-most common among non-Mäori **Hospitalisations** • 537 hospitalisations for intentional injury over 5 years 2001-2005 (average 107 per year, 8 percent of all injury-related hospitalisations) • 380 hospitalisations from 2001-2005 for intentional self-harm (average 76 per year) • 157 hospitalisations for assaults (average 31 per year) • Overall, intentional self-harm is the 4th most common cause of injury-related hospitalisation • Intentional self-harm is the most common cause of injury-related hospitalisation for females aged 20-29, 30-39 40-49 • Intentional injuries 15 percent of all injury-related hospitalisations for Mäori (7 percent for non-Mäori) **Emergency Department attendances** • 223 ED attendances for assault in 2005 (5 percent of all injury-related attendances) • Males have 3 times the age-standardised attendance rates of females males for assault (587 per 100,000 compared to 191 per 100,000) • 10-19 and 20-29 year olds the most likely age groups to attend EDs for assault-related injury **Police** • 890 recorded violent offences in New Plymouth Policing Area in 2005 • 75 recorded sexual offences in 2005 **Coroner suicide data** • 93 suicides investigated by coroner from 1996-2005 in North Taranaki • 80% of suicides were by males • The most common ages for committing suicide were 30-39 and 20-29 • The most common methods were hanging (42%), carbon monoxide poisoning (26%) and gunshots (11%)	**Population groups and types of injuries** • Family violence - financial difficulties, poverty, unemployment, lack of family support, alcohol, drugs; women aged 18-mid 30s • Other assaults - alcohol, drugs, sexual assaults • Suicide / attempted suicide - people under 25, older and middle-aged males; psychiatric history (depression, previous suicide attempts) **Existing interventions** • Te Rito NZ Family Violence Prevention Strategy (Taranaki Te Rito Management Group) **Suggested interventions** • Public awareness campaign for family violence (Te Rito national campaign is planned for 2007) • Additional free family intervention programmes for family violence victims • Implementation of national suicide strategy	**NPiS Priorities** Long-term: 2005-2010 • Mäori intentional **NZIPS Priorities** Covers 2 of the 6 national priorities: • Suicide and deliberate self-harm • Assault

4. YOUNG PEOPLE / RANGATAHI (15-24)

STATISTICAL ANALYSIS	COMMUNITY CONSULTATION	EXISTING PRIORITIES
Deaths • An average of 3 10-19 year olds and 4 20-29 year olds die from injuries each year in New Plymouth District • At 60 deaths per 100,000 in 2000-2003, 20-29 year olds have the second highest rate of injury-related deaths after 80+ year olds • The most common causes of injury-related deaths among 10-19 year olds are transport accidents, accidental poisoning and intentional self-harm. • The most common causes of injury-related deaths among 20-29 year olds are intentional self-harm and transport accidents • 20-29 year olds have the highest rate of intentional injury death in New Plymouth District (28 per 100,000) **Hospitalisations** • In New Plymouth District each year there are 322 hospitalisations for 10-29 year olds for injuries (183 10-19 year olds, 139 20-29 year olds) • 20-29 year olds have the third highest rate of injury hospitalisation (1977 per 100,000 in 2001-2005) after 80+ and 70-79 year olds • Males aged 20-29 are 3 times more likely to be hospitalised for injury than females. Males aged 10-19 are nearly twice as likely as females to be hospitalised for injury • The most common causes of injury hospitalisations in 10-19 year olds are falls, transport accidents and exposure to inanimate mechanical forces • The most common causes of injury hospitalisation in 20-29 year olds are: for males exposure to inanimate mechanical forces, transport accidents and self-harm; for females intentional self-harm and transport accidents • 20-29 year olds have the highest rate of hospitalisation for intentional injury of all age groups (372 per 100,000)	**Population groups and types of injuries** • Bruises and lacerations – falls, violent and sexual assaults, alcohol, drugs, inexperience and carelessness at work • Fractures and head injuries – vehicle crashes • Sprains and strains – lack of knowledge, poor techniques, not wearing safety gear, use of substandard equipment in sports, participation in extreme sports **Existing interventions** • General sports safety campaigns (sports organisations) • National road safety campaigns • Sports coaching and upskilling seminars (sports organisations) • THINKsmart sports clubs accreditation (intersectoral) • DrinkSafe 4 Youth (Police) **Suggested interventions** • Parents need to take more responsibility for their children's safety – they should not 'hand over the car keys' or encourage unsafe alcohol use • Shock tactics to reduce car crashes among young Mäori (e.g. displaying a car wreck at schools) • A scoping study on sports injuries among young people (and children) is planned by the Health Promotion Unit of Taranaki DHB	**NPiS Priorities** Short-term: 2002-2004 • Youth road Medium-term: 2003-2007 • Youth sport Long-term: 2005-2010 • Youth violence **NZIPS Priorities** • Young people not specifically mentioned but the national strategy does focus on motor vehicle traffic crashes, suicide and deliberate self-harm, and assault

(Continued overleaf)

4. YOUNG PEOPLE / RANGATAHI (15-24) (continued)

STATISTICAL ANALYSIS (continued)

Emergency Department attendances

- In 2005 in New Plymouth District, 1684 10-19 year olds and 1146 20-29 year olds attended public hospital Emergency Departments for injury
- Of all age groups, rates of injury-related ED attendance were highest in 10-19 year olds (16,399 per 100,000) and second highest in 20-29 year olds (16,276 per 100,000)
- Males aged 10-19 are 1.7 times more likely to attend EDs for injury than females. Males aged 20-29 are nearly 3 times more likely to attend EDs for injury than females
- Young people are most likely to attend EDs for blunt trauma and falls
- Young people who attend EDs are most likely to have sustained their injuries in domestic situations or sports / recreation venues

ACC claims

- In 2005/06 there were 244 ACC new claims for 10-19 year olds and 352 new claims for 20-29 year olds
- 20-29 year olds have the highest ACC new claim rates of all age groups (4999 per 100,000 in 2005 / 06)
- Males aged 20-29 are 4 times as likely to have claims than females. Males aged 10-19 are twice as likely as females to have claims

Road crashes

- People aged 10-19 accounted for 28% of crash casualties in 2001-2005, while people aged 20-29 accounted for 19% of crash casualties

Police

- 11% of people apprehended for violent offences are aged 14-16; 18% are 17-20 and 29% are 21-30
- 9% of people apprehended for sexual offences are aged 14-16; 14% are 17-20 and 22% are 21-30

Coroner suicide data

- From 1996 to 2005, 9% of suicides investigated by the coroner were for people under 20 years old and 20% were 20-29

5. CHILDREN / TAMARIKI

STATISTICAL ANALYSIS

Deaths

- On average, 1 0-9 year old and 3 10-19 year olds die from injury each year in Taranaki
- Children aged 0-9 have the lowest death rates from injury and 10-19 year olds have the third lowest death rates
- Accidental drowning and submersion and other accidental threats to breathing were the most common causes of injury death among 0-9 year olds in 2000-2003
- ransport accidents, accidental poisoning and intentional self-harm were the most common causes of injury death among 10-19 year olds
- From 2000-2003, there were no intentional injury deaths among 0-9 year olds and only 2 among 10-19 year olds

Hospitalisations

- An average of 168 0-9 year olds and 183 10-19 year olds are hospitalised each year for injury in New Plymouth District
- Children have hospitalisation rates for injury that are in the mid-range compared with other age groups
- Males have injury hospitalisation rates that are 26% above female rates in the 0-9 year age group
- In the 10-19 age group, males had nearly double the rates of injury hospitalisation of females
- By far the most common cause of injury-related hospitalisations among 0-9 year olds was falls. Next came exposure to inanimate mechanical forces and then transport accidents. These same three injury causes were the most common for 10-19 year olds, although falls did not dominate as much
- 6 children aged 0-9 and 131 aged 10-19 were hospitalised for intentional injuries over the period 2001-2005

Emergency Department attendances

- In 2005 there were 1017 ED visits by 0-9 year olds and 1684 by 10-19 year olds for injury
- Males aged 10-19 were nearly 70% more likely to attend EDs for injury than females of the same age
- The first and second most common injuries for which 0-9 year olds visit EDs are falls and blunt trauma. The first and second most common injuries for 10-19 year olds are blunt trauma and falls
- By far the most common places where 0-9 and 10-19 year olds attending EDs are injured are domestic situations. Sports / recreation venues are also common for 10-19 year olds

ACC claims

- By far the lowest rates of ACC new entitlement claims in New Plymouth District are for 0-9 year olds. The next lowest rate is for 10-19 year olds

Road crashes

- In 2001-2005, young people aged 10-19 accounted for 28% of traffic crash casualties in 2001-2005. Children aged 0-9 accounted for 4% of crash casualties
- In a 2005 survey of child restraint use in New Plymouth District, 92% of children under 5 were using an infant seat, child seat, booster seat or harness (compared to 89% in NZ)

COMMUNITY CONSULTATION

Population groups and types of injuries

- Poisonings – paracetamol, winter ailment medications, parents' and grandparents' medicines, household cleaners and other household products
- Bruises, fractures, cuts, lacerations – falls from playground equipment, trees, cycles, scooters, skateboards, stairs; car crashes; pedestrians (backing cars, school crossings); child abuse
- Burns and scalds – heaters, fires, hot water; baby walkers; parental ignorance of child development; young children carrying infants

Existing interventions

- Well child care service providers including home safety checks and Well Child care Week
- Kidsafe Trust including Kidsafe Week
- National child restraint training programme, local car seat safety initiatives (Safe To Go)
- Safety component of school health and physical education curriculum
- Waitara Initiative Supporting Employment (WISE) Better Homes project includes installation of smoke alarms, stair and fire guards (ACC, DHB, PHO)
- PHO / Kidsafe general practice poisonings project
- Health Promoting Schools (DHB)
- School crossing safety (primary schools)

Existing interventions (cont.)

- Falls programme (ACC, Kidsafe, Tamariki Ora)
- Follow up of all children hospitalised for injury (DHB)
- Pool fencing legislation and surveillance
- Baby mats with safety messages (ACC)
- Postcards to new parents (Plunket)
- School playground safety workshops
- CYFS
- Strengthening Families Forum (intersectoral)

Suggested interventions

- Further efforts to make school crossings safer through better parental awareness and increased surveillance of speed limits
- Safety initiatives in intermediate schools
- Mobilisation of community against child abuse
- Involvement of children in designing injury prevention programmes

EXISTING PRIORITIES

NPiS Priorities

Short-term: 2002-2004

- Children falls

NZIPS Priorities

- Not specifically mentioned but relevant national priorities include falls, drowning and motor vehicle traffic crashes

6. PEOPLE IN THE WORKPLACE

STATISTICAL ANALYSIS

Deaths and hospitalisations

- No data available on whether these are work-related or not

Emergency Department attendances

- In 2005, 538 people from New Plymouth District (431 males and 107 females) attended public hospital Emergency Departments for injuries occurring at work
- Injuries occurring at work account for 12% of injury-related ED attendances
- Males are over 4 times more likely than females to attend EDs for work-related injuries
- People aged 20-29 have the highest rates of ED attendances for injury (27% of injury-related attendances in this age group are work-related)

ACC claims

- Overall in 2005 / 06, 639 or 29% of ACC new entitlement claims in New Plymouth District were work-related
- Manufacturing (19%) was the most common industry for which work-related new claims were made, followed by agriculture / forestry / fishing (16%) and construction (15%)
- In terms of rates per 100,000 workers, the construction industry had the highest new claim rate, followed by transport / storage and agriculture / forestry / fishing
- In 2005/06, 208 or 10% of new entitlement claims were for injuries occurring in industrial places; 246 (11%) were for injuries occurring at commercial or service locations; and 100 (5%) were for injuries occurring on farms
- The most common diagnoses for new claims relating to injuries sustained in industrial places are soft tissue injuries (43%) and deafness (20%)
- The most common diagnoses for new claims relating to injuries occurring in commercial / service locations are soft tissue injuries (48%) and fracture / dislocations (20%)
- The most common diagnoses for new claims relating to injuries occurring on farms are soft tissue injuries (42%) and fracture dislocations (30%)

COMMUNITY CONSULTATION

Population groups and types of injuries

- Manual workers – riggers, scaffolders, construction workers, fire safety officers – cuts, bruises, strains/sprains, finger amputations – heavy machinery, high pressure gas, heights, confined spaces, fatigue
- Young workers – more serious injuries because of inexperience and immaturity
- Older workers – back, neck and knee strains – reduced agility – carelessness because of over-familiarity, take short-cuts, prolonged exposure to hazardous substances
- Migrants – communication difficulties around health and safety, inexperience
- Drivers – serious injuries / death – fatigue, poor road design, large vehicles, ageing workforce
- Farmers (and their children) – chemical burns, farm bikes, ATVs, animal unpredictability, resistance to safety measures, combined home and workplace
- Workers in small to medium workplaces – lack of safety culture compared to large companies

Existing interventions

- Workplace health and safety programmes by large companies (Shell Todd, ENSCO, Port Taranaki)
- Taranaki Health Safety and Environment (HSE) Centre (ACC, DHB, medium and large industries)
- Passport to Safety health and safety awareness programme for 15-24 year olds (HSE Centre, ACC, Dept of Labour)
- Farmsafe workshops (Federated Farmers, ACC, Agriculture ITO, Agriculture NZ, Telford Rural Polytechnic)

Suggested interventions

- Regular first aid training for school staff
- Farm safety days to be held at local schools including use of local human interest stories concerning farm injuries
- More regular local chemical disposal days
- National driver fatigue awareness campaign
- Improve local roads' 'black spots'
- Promote 'employer of choice' concept to attract workers to safe working environments

EXISTING PRIORITIES

NPiS Priorities

Medium-term: 2003-2007

- Workplace (agriculture)

NZIPS Priorities

- Workplace injuries (including occupational diseases) is 1 of the 6 national injury prevention priority areas

7. MÄORI

STATISTICAL ANALYSIS	COMMUNITY CONSULTATION	EXISTING PRIORITIES
Deaths • 20 deaths over 4 years 2000-2003 (average 5 per year) • Age-standardised rates (ASRs): 64 per 100,000 for Mäori compared with 32 per 100,000 for non-Mäori • Most common causes = intentional self-harm, transport accidents • Intentional injuries 40% of injury deaths for Mäori (25% for non-Mäori) **Hospitalisations** • 757 hospitalisations over 5 years 2001-2005 (average 151 per year) • ASRs 1819 per 100,000 for Mäori compared with 1800 per 100,000 for non-Mäori • Most common causes = falls, exposure to inanimate mechanical forces, transport accidents • Mäori age-specific rates for injury hospitalisation slightly higher than non-Mäori in every age group except 10-19 and 80+ • Intentional injuries 15 percent of all injury-related hospitalisations for Mäori (7 percent for non-Mäori) **Emergency Department attendances** • 923 attendances in 2005 • ASRs: 10,538 per 100,000 for Mäori compared with 11,265 per 100,000 for non-Mäori • Mäori had lower age-specific rates for 0-9, 10-19, 20-29, 60-69, 80+ (compared to non-Mäori) **ACC claims** • 10 percent of new claimants were Mäori **Road crashes** • In 2005, Mäori comprised 19 percent of drivers who were road crash casualties in New Plymouth District **Police** • 45% of people apprehended for violent offences were Mäori • 23% of people apprehended for sexual offences were Mäori	**Population groups and types of injuries** • Tamariki - falls, burns, scalds, poisonings, non-compliance with car restraints • Rangatahi – road crashes, use of unwarranted and unsafe cars, risky and aggressive behaviours • Kaumätua – slips, trips, falls (risk increased by poor vision, underlying medical conditions, failure to identify potential risks at home) • Sports injuries – high level of participation in contact sports, lack of knowledge of available safety gear / reluctance to use safety gear **Existing interventions** • Tamariki falls project (ACC / Kidsafe) • Kaumätua Otago Exercise Programme (ACC/DHB) • Mäori specific services (Piki te Ora, Manaaki Oranga) • Access to treatment and follow-up of injuries and ACC entitlements (Mäori, ACC, Ministry of Health) **Suggested interventions** • Scoping of sports injuries information • Regular surveys of Mäori injury patterns • 'Survivor Idol' road safety promotional event (music and dance competition)	**NPiS Priorities** Short-term: 2002-2004 • Mäori road Long-term: 2005-2010 • Mäori sport • Mäori intentional **NZIPS Priorities** Mäori not specifically mentioned, although relevant national priorities are falls, motor vehicle traffic crashes, suicide and deliberate self-harm, and assault.

8. PARTICIPANTS IN SPORT OR RECREATION

STATISTICAL ANALYSIS	COMMUNITY CONSULTATION	EXISTING PRIORITIES
Deaths and hospitalisations • No data available on whether these are sports / recreation related or not **Emergency Department attendances** • Sports / recreation venues are the second most common places where injuries occur to NPD people who attend public hospital Emergency Departments (14% of injury-related ED attendances) • In 2005, 654 people (449 males and 205 females) attended EDs for injuries that occurred at sports / recreational venues • Males have ED attendance rates for sports / recreational injuries that are more than double those of females • Compared to other age groups, 10-19 year olds and 20-29 year olds were far more likely to require ED treatment for injuries sustained at sports / recreation venues **ACC claims** • In 2005 / 06, 423 (20%) of ACC new entitlement claims were for injuries occurring during sport / recreation; this was the most common activity being participated in prior to injury • Rugby union (17%), netball (10%) and soccer (10%) are the most common types of sports / recreation activities in which injuries occur leading to ACC claims • In 2005 / 06, 391 or 18% of new claims were for injuries occurring at sports / recreation venues (278 males and 113 females) • 21% of new claims made by males are for injuries occurring at sports / recreation venues, compared to just 14% for females • By far the most common diagnoses for injuries occurring at sports / recreation venues are soft tissue injuries (60%) and fracture / dislocations (33%)	**Population groups and types of injuries** • Contact sports – sprains, fractures, bruises, concussion, cuts and grazes, head and spinal injuries – failure to wear protective gear, poor techniques, injuries (concussion) not taken seriously • Extreme sports – includes mountaineering and mountain biking – sprains, fractures, bruises, concussion, cuts and grazes, head and spinal injuries – inadequate equipment, tourists (and others) not taking the mountain seriously, weather, high tech mountain bikes outstripping riders' capabilities • Athletics – sprains and strains – poor equipment (e.g. shoes) • Veteran sports – sprains and strains – age-related physical conditions **Existing interventions** • Injury risk assessment and management (Sport Taranaki) • Green prescription / Active Families (GPs, SPARC, local sports trusts) • Push Play (SPARC) • Best practice programmes for coaches (sports trusts and sports codes) • Active schools (secondary schools) • Otago Exercise Programme • Tai Chi • New Plymouth Coastal Walkway (Keeping fit reduces injuries) **Suggested interventions** • Scope whole area of sports injuries (Health Promotion Unit of DHB planning to do this 2006/07)	**NPiS Priorities** Short-term: 2000-2004 • Sport (all ages) Medium-term: 2003-2007 • Youth sport Long-term: 2005-2010 • Mäori sport **NZIPS Priorities** • Not specifically mentioned

OTHER PRIORITY AREAS

Other priority areas that could be considered are:

- drowning (which accounted for 6 deaths in 2000-2003, including 3 under 19-year-olds)
- injuries occurring to people at home (this was cited as a priority area in the last needs assessment, but not in the current one)
- males (many of the statistical indicators show that males have much higher injury rates than females, particularly in younger age groups).

Conclusion

This needs assessment has updated statistics on injury patterns among New Plymouth District residents since the previous needs assessment in 2001.

It has also described the development of the New Plymouth injurySafe community injury prevention initiative during this time; and sought feedback from community representatives about priority injury prevention issues in the District.

There have been positive changes in some of the injury statistics during the period, although there are still some groups in the community that are at relatively high risk of injury. NPiS has been very active through the projects it has been involved in, its planning processes and its successful application to become a WHO Safe Community. NPiS is now continuing to strengthen its infrastructure and expand its activities, and this should help it to address some of the injury issues that are still causing concern in the community.

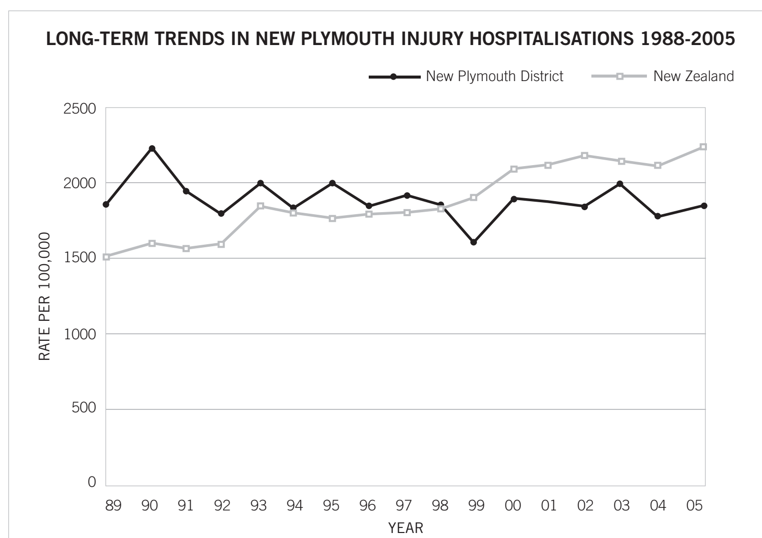
CHANGES IN INJURY PATTERNS

While the current needs assessment was not designed to statistically identify changes in New Plymouth District's injury patterns since the previous needs assessment, some fairly consistent trends can be described for some of the injury data. These trends are likely to be caused by a number of factors, including various national as well as local influences (possibly including the NPiS initiative).

Trends in injury-related deaths are difficult to assess because of the relatively small numbers occurring locally each year (causing quite large random variations) and a change in the ICD classification system in the year 2000. From 2000-2003, unlike the national situation, local injury mortality rates appeared to be heading downwards. This followed a previous pattern from 1989-2000, where New Plymouth District had age-standardised mortality rates that were initially below, then were similar to national rates.

Trends in injury-related hospitalisation rates can be considered to be more reliable because of the much larger numbers. Recent trends show that from 2000 onwards, national age-standardised hospitalisation rates for injury steadily increased, while New Plymouth District rates decreased, with the gap between local and national rates progressively widening. This contrasts with trends in the earlier period from 1989 to 1997, where injury hospitalisation rates in New Plymouth District were higher than the national average. (See graph).

The age-standardised rate of injury-related public hospital Emergency Department attendance among New Plymouth District residents was slightly higher in 2005 than in 2000.



The age-standardised rate of ACC new entitlement claims in New Plymouth District was also slightly higher in 2005 / 2006 than in 2000 / 2001 (as it was, too, for New Zealand as a whole).

In New Plymouth District from 2000 to 2003, rates of injury road traffic crashes per 100,000 population were higher than the national average. The rates consistently increased over 2000-2003, as did the New Zealand rates. However, after this in New Plymouth District, the rate dropped to become similar to the national average rate in 2004 and 2005. Earlier data for the five years 1996-2000 showed a progressive decrease in both New Plymouth District and national rates of injury road traffic crashes.

Police statistics showed an increase in the number of recorded violent offences between the two five-year periods 1996-2000 and 2001-2005, which reflected a similar trend nationally. There was a slight decrease in the number of sexual offences over the same period.

COMMUNITY READINESS

Assessing the readiness of New Plymouth District for a community injury prevention initiative was not a specific aim of the current project. However, the information we collected enables us to make some comments that could contribute towards this process. Further information would be needed to more comprehensively assess New Plymouth District's community readiness for such an initiative.

In making these comments, we have used the six dimension headings from the community readiness tool developed by the Tri-Ethnic centre of Colorado State University (Edwards et al. 2000; Oetting et al. 2001; Slater et al. 2005; Thurman et al. 2003).

EXISTING EFFORTS – PROGRAMMES, ACTIVITIES, POLICIES

Since its establishment in 2000 (originally as the New Plymouth Injury Safe Advisory group), the New Plymouth injurySafe group has been very active in developing, running and supporting activities and programmes to prevent injury in New Plymouth District.

As well as these activities, the group has (among other things): commissioned two community injury needs assessments (including the current one); developed a strategic plan and an annual plan; successfully applied for World Health Organisation Safe Community accreditation; and worked on its intersectoral relationships within the group and with others outside the group.

While an evaluation of the NPiS initiative as a whole has not yet been carried out, smaller evaluations of individual activities are ongoing. To date, these evaluations have included pre- and post-intervention surveys, random telephone surveys, focus group interviews of activity participants, and injury data analysis. NPiS personnel also contributed to the formative evaluation of the local ThinkSafe community project.

COMMUNITY KNOWLEDGE / AWARENESS OF THESE EFFORTS

There is indirect evidence that there is a reasonable degree of knowledge among community organisations and the wider community. For example:

- a high number of people and organisations participating in specific NPiS activities such as the Otago Exercise Programme, Tai Chi and the THINKsmart programmes
- the high level of response, such as letters to the editor, after stories about NPiS activities in the media, in particular the WHO accreditation as a Safe Community.

However, a few people consulted for this project believed that increasing awareness in the wider community, and increasing the input of 'grassroots' community and service providers into NPiS activities, may be areas that could benefit from further effort in the future.

Eventually it may be helpful to more directly measure the level of awareness of NPiS activities among members of the wider community, for example through a community survey. However, this is likely to require special funding.

LEADERSHIP – APPOINTED LEADERS AND INFLUENTIAL COMMUNITY LEADERS

The New Plymouth Injury Safe Advisory Group, and subsequently New Plymouth injurySafe, have provided a great deal of leadership in establishing a community injury prevention initiative in New Plymouth District. The intersectoral group includes some (possibly most) of the key organisations responsible for injury prevention and general health promotion in the local population, particularly government agencies, the Health Promotion Unit of Taranaki DHB and Tui Ora Ltd. The NPiS group has also fostered New Plymouth District Council's leadership in this issue. A high level of leadership skills by the group was also necessary in the process of the District successfully applying for accreditation as a WHO Safe Community.

COMMUNITY CLIMATE – EXISTING COMMUNITY ATTITUDES TO A PARTICULAR ISSUE

According to feedback from key people in the community, New Plymouth District has a good history of organisations working collaboratively. Working across sectors on the issue of injury prevention was seen to be essential and beneficial because of:

- the large scale of the injury prevention issue
- the potential to use a holistic approach to the problem
- the ability to use a more consistent approach across organisations
- greater efficiency in being able to share funding and other resources to address the issue
- the potential to reduce duplication and waste of resources across organisations.

Local organisations are now said to be very supportive and committed to the idea of safety promotion and injury prevention. The current economic growth of New Plymouth District and the increase in tourism also means that it is necessary to ensure a safe environment.

However, little is directly known about the wider community's general attitudes towards, and levels of support for, injury prevention. While there has been good support for many NPiS activities, resistance to safety measures among some groups (such as farmers and sports clubs) was identified as an issue in the community consultation.

COMMUNITY KNOWLEDGE ABOUT THE ISSUE

The results of two needs assessments, statistical analyses relating to specific NPiS activities, and the WHO Safe Community accreditation application process, mean that there is quite a high level of knowledge, at least among leading injury prevention organisations, about the degree and nature of injury patterns in New Plymouth District. There is also likely to be developing knowledge about what works, and what is less successful, in preventing injury in the local community as activities are evaluated.

However, there is no direct knowledge about how much the wider community (the 'general public') knows about injury issues. Many of those who have participated in NPiS education activities may now have improved knowledge about specific injury issues (for example, falls, burns). However, again because a general community survey has not been carried out, the local population's level of knowledge and use of injury prevention measures appears to be largely unknown.

The community consultation suggested that increasing the community's knowledge and awareness of injury issues would increase its ownership and responsibility for prevention measures such as the NPiS initiative.

RESOURCES AVAILABLE TO ADDRESS THE ISSUE – INCLUDING FUNDING, TRAINED STAFF AND TIME

The NPiS initiative currently has direct funding from the ACC, Ministry of Health, Tui Ora Ltd, and Land Transport New Zealand. There are also the equivalent of 4.2 full-time staff working on injury prevention in ACC, Taranaki DHB, New Plymouth District Council and Tui Ora. Additional time is given from staff from organisations like the Police, Fire Services, Plunket, Department of Labour, Occupational Safety and Health and so on.

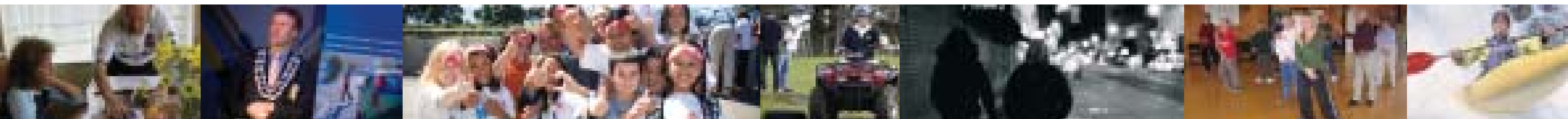
Other organisations and businesses give in-kind contributions such as discounted products and free equipment for specific projects.

HOW READY IS NEW PLYMOUTH DISTRICT FOR A COMMUNITY INJURY PREVENTION INITIATIVE?

Considering the evidence summarised above, New Plymouth District has obviously achieved many of the nine 'stages of readiness' outlined in the community readiness model.

A lack of direct evidence on the awareness, knowledge, attitudes and behaviour of the general population towards injury prevention makes it difficult to assess exactly which stage the NPiS is at. However, it appears to be around stage 7 (stabilisation) or stage 8 (confirmation / expansion); with elements of stage 9 (professionalisation / community ownership).

To request an electronic copy of the full report, New Plymouth District 2006 Community Injury Prevention Needs Assessment (Word document 2MG) and appendices (Word document 2MG) email kath.forde@acc.co.nz



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