

New Plymouth District Community Injury Prevention Needs Assessment 2011

**Prepared for
New Plymouth injury Safe**

by

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Disclaimer

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List of Acronyms

ACC	Accident Compensation Corporation
ASR	Age-standardised rate
BeST	Be Safe Taranaki Centre
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
ISC	International Safe Community (formerly known as WHO Safe Community)
NPD	New Plymouth District
NPDC	New Plymouth District Council
NPiS	New Plymouth injury Safe
NZDep2006	New Zealand deprivation index, 2006
NZHis	New Zealand Health Information Service
NZIPS	New Zealand Injury Prevention Strategy
PHO	Primary Health Organisation
SCFNZ	Safe Communities Foundation New Zealand
TDHB	Taranaki District Health Board
TLA	Territorial Local Authority
WHO	World Health Organization

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Note to readers

Detailed statistical tables and other background information for this report are contained in the following stand-alone documents:

- Appendix Volume One: Statistical Tables
- Appendix Volume Two: Consultation Documents.

Summary

New Plymouth District Community Injury Prevention Needs Assessment 2011

Purpose of this report

This report provides detailed statistics on injury patterns and safety-related risk factors for New Plymouth District. These are intended to help underpin and guide development of injury prevention and safety strategies in the district over the next five years.

The report also presents results of a community consultation to find out what people in the district consider to be the main injury issues confronting the New Plymouth population and the best ways to address them. Part of the consultation included asking people for their views about the appropriateness and impact of New Plymouth injury Safe and the New Plymouth Safe Community initiative.

Injury deaths

Injury deaths are arguably the most extreme and undesirable outcome of injury events. In 2004–2008, an average of 31 New Plymouth District people died each year as a result of injury.

The three leading causes of injury deaths in New Plymouth District are intentional self-harm (29%), transport accidents (26%) and falls (23%). Together these three causes account for 78% of all injury deaths.

Other notable causes are accidental poisoning by and exposure to noxious substances (5%), assault (5%) and accidental drowning and submersion (4%).

Altogether, 65% of New Plymouth District injury deaths are from unintentional injury and 33% are from *intentional* injury (intentional self-harm plus assaults). However, in the 20–29, 30–39 and 60–69 age groups, over half of all injury deaths are from *intentional* injury.

Quick facts: injury deaths in New Plymouth District 2004–2008

Injury deaths		Main causes of injury deaths		Age-group injury death rates per 100,000 population (5 year average)		
Year	Total			Age	Male	Female
2004	37	Intentional self-harm (suicide)	29 %	0–9	<1	18
2005	28	Transport accidents	26 %	10–19	40	4
2006	21	Falls	23 %	20–29	67	22
2007	40	Poisoning	5 %	30–39	97	12
2008	28	Assault	5 %	40–49	70	22
5-year average	31	Accidental drowning	4 %	50–59	67	17
				60–69	38	24
				70–79	71	23
				80+	253	193
				All ages	51*	18*
Māori injury death rates						
<i>per 100,000 population (5 year average)</i>						
		<i>All ages</i>				
Māori	74*					
Non- Māori	31*					
*age-standardised						

*age-standardised

Injury hospitalisations

Hospitalisation means a day patient or inpatient admission to a public hospital. It excludes emergency department visits. Hospitalisation often implies an injury event of some seriousness requiring treatment with specialised equipment and personnel. It may also involve a lengthy period of recovery or rehabilitation in hospital, at home or in some other facility.

In the five years 2006–2010, people in New Plymouth District had a total of 8,149 injury hospitalisations, an average of 1,630 injury hospitalisations each year.

Falls are by far the most common reason New Plymouth people are hospitalised for injury (41% of all injury hospitalisations). Next most common are exposure to inanimate mechanical forces (15%) and transport accidents (14%). Intentional injuries (self-harm plus assault) make up 9% of all injury hospitalisations.

Falls on the same level, especially falls on the same level resulting from either slipping, tripping or stumbling, comprise the majority of fall hospitalisations. Contact with a sharp glass, knife, sword, dagger or non-powered hand tool comprised 23% of injuries caused by inanimate mechanical forces.

Car occupants (29%), motorcycle riders (27%) and pedal cyclists (17%) featured prominently in the injury hospitalisations caused by transport-related accidents.

Women in the 80+ age group had the greatest risk of injury hospitalisation in 2006–2010, with about a one in 10 chance of being hospitalised in any given year (10,291 injury hospitalisations per 100,000). The next highest risk group was men in the 80+ age group (8,355 injury hospitalisations per 100,000), followed by men in the 20–29 age group (3,408 injury hospitalisations per 100,000).

Intentional self-harm (30%) was the leading cause of injury hospitalisation for females aged 30–39 and aged 40–49.

In all age groups except 0–9, Māori had higher or slightly higher injury hospitalisation rates than non-Māori.

Quick facts: hospitalisations for injury in New Plymouth District 2006–2010

Injury hospitalisations – all ages			Main causes of injury hospitalisation		Age-group injury hospitalisation rates		
Year	Total admissions	Rate per 100,000 population			per 100,000 population (5-year average)		
			Falls	41 %	Age	Male	Female
			Inanimate mechanical forces	15 %	0–9	1,616	1,432
			Transport accidents	14 %	10–19	2,691	1,195
2006	1,295	1,549*	Intentional self-harm	6 %	20–29	3,408	1,402
2007	1,326	1,550*	Over-exertion, travel, privation	4 %	30–39	2,567	1,525
2008	1,589	1,926*			40–49	2,105	1,157
2009	2,026	2,574*	Animate mechanical forces	4 %	50–59	2,016	1,349
2010	1,913	2,261*	Assault	3 %	60–69	1,746	1,466
			Poisoning/noxious substances	2 %	70–79	2,775	3,346
					80+	8,355	10,291
					All ages	2,416*	1,504*
Māori injury hospitalisation rates							
per 100,000 population (5-year average)							
	All ages						
Māori	2,287*						
Non- Māori	2,024*						
*age-standardised							

Emergency department visits for injury

Taranaki District Health Board has emergency departments at Taranaki Base Hospital in New Plymouth and Hawera Hospital. Emergency departments are typically the first place people go to or are taken when seeking urgent public hospital treatment for injury. Even injury cases later coded as inpatient hospital admissions are likely to have been first treated in a hospital's emergency department.

In 2010, New Plymouth District residents made a total of 25,080 emergency department (ED) visits. Of these, 7,666 (31%) were visits for injury treatment.

Forty-five percent of ED visits for injury treatment were by children and young people aged 0–24 years. Thirty-nine percent were by people aged 25–59 years. Sixteen percent were by people aged 60 or more.

In terms of age-specific risk, males aged 20–24 were the most likely to visit an emergency department for injury (24,493 visits per 100,000 population) followed by males aged 15–19 (22,351 visits per 100,000 population).

Among females, those aged 80 or more were the most likely to visit an emergency department for injury (14,273 visits per 100,000) followed by 15–19 year olds (13,347 visits per 100,000).

The most common ED visit injury cause in 2010 was blunt trauma, with the highest rates in the 20–24, 15–19 and 25–29 age groups. Second most common was falls, with the highest rates in the 80+, 5–9, 10–14, 15–19 and 70–79 age groups.

In terms of location, the biggest group of ED injury cases occurred in the home. People in the age groups 80+, 0–4 and 20–24 had the highest rates of injury occurring at home.

Next most common was injuries at sport and recreation places. People in the 15–19, 20–24 and 10–14 age groups had the highest rates of injury at sport and recreation places.

Quick facts: emergency department (ED) visits for injury in New Plymouth District

Injury ED visits – all ages			Main causes of injury ED visits – 2010 ⁺		Age-group injury ED visit rates – 2010 per 100,000 population		
Year	Total ED visits for injury	Rate per 100,000 population			Age	Male	Female
2000	6,531	10,136*	Blunt trauma	33 %	0–4	12,340	9,793
2005	7,249	11,567*	Fall	31 %	5–9	10,886	11,168
2010	7,666	11,434*	Penetrating trauma	11 %	10–14	16,353	11,037
			Strain	8 %	15–19	22,351	13,347
			Foreign body	5 %	20–24	24,493	11,232
			Assault	3 %	25–29	16,780	9,949
			Overdose	3 %	30–39	13,309	8,091
			Bite	2 %	40–49	10,548	5,981
			Allergic	2 %	50–59	7,568	6,344
			⁺ percentage of injury visits where cause recorded		60–69	6,323	4,513
Māori injury ED visit rates – 2010					70–79	6,271	7,122
per 100,000 population					80+	11,119	14,273
	All ages				All ages	13,640*	9,113*
Māori	13,442*						
Non- Māori	11,946*						
*age-standardised							

New ACC entitlement claims

'New entitlement claims' are claims to ACC for medical expenses, rehabilitation costs and compensation for lost income due to injury. Claims for primary health care only (which make up more than 90 % of all new claims registered nationally), rejected claims, dental-only claims and 'ongoing' claims are not included in this analysis.

In the eight financial years from 2000/01 to 2007/08, the number of accepted new ACC entitlement claims for New Plymouth District steadily increased, from a total of 1,829 in 2000/01 to a total of 2,400 in 2007/08. However, the two most recent years have seen a sizeable fall in the number of accepted new claims, dropping to 1,935 in 2010/11.

Of the 1,935 accepted new claims in 2010/11, 61% were for males and 39% for females. Males

aged 20–29 had the highest rate of accepted new claims, followed by males aged 30–39 and 40–49

Home was the most common place where injuries occurred resulting in ACC new entitlement claims. Next were sport and recreation places, then the road or street. Almost half of all female new entitlement claims were for injuries sustained in the home. Males, by contrast, had a higher proportion of their injuries sustained at recreation or sports places, industrial places, and farms.

Rugby union was the sport / recreation with the highest number of new entitlement claims, followed by netball, rugby league, cycling and soccer. The largest proportion of work-related claims came from the manufacturing and construction sectors, followed by health and community services, and retail.

Quick facts: new ACC entitlement claims for New Plymouth District

Accepted new ACC entitlement claims		Scene of accident, new entitlement claims, 2010/11	Age-group, new entitlement claims, 2010/11 per 100,000 population		
Year	Total		Age	Male	Female
2000/1	1,829	Home 36 %	0–9	80	88
2001/2	1,883	Recreation or sports 23 %	10–19	2,543	1,166
2002/3	1,901	Road or street 10 %	20–29	6,898	2,400
2003/4	2,053	Commercial / service location 9 %	30–39	4,831	2,364
2004/5	2,196	Industrial place 6 %	40–49	4,057	2,259
2005/6	2,161	Farm 5 %	50–59	3,354	2,846
2006/7	2,260	Place of medical treatment 3 %	60–64	3,507	1,875
2007/8	2,400	School 2 %	65+	1,881	2,770
2008/9	2,358	Other / unknown 6 %	All ages	3,219*	1,693*
2009/10	2,068				
2010/11	1,935				
Māori new entitlement claims, 2010/11 per 100,000 population		Sports and recreation with highest ACC new entitlement claims		Industries with highest ACC new entitlement claims	
	All ages	Rugby union 20 %	Manufacturing	16 %	
Māori	2,292*	Netball 9 %	Construction	15 %	
Non- Māori	2,742*	Rugby league 7 %	Health & community services	9 %	
		Cycling 7 %	Retail trade	7 %	
		Soccer 6 %	Personal and other services	6 %	
		Trail biking, motocross 5 %	Property and business services	5 %	
		Basketball 4 %	Wholesale trade	5 %	
		Skateboarding 3 %	Transport & storage	4 %	
		Outdoor cricket 3 %	Education	3 %	
		Touch rugby 3 %	Cultural & recreational services	2 %	
			Accommodation, cafes and restaurants	1 %	
			Electricity, gas & water supply	1 %	
			Mining	1 %	

*age-standardised

Other 'hidden' injuries in the community

While injury deaths, hospitalisation and emergency department visits are (and should be) central to any statistical analysis of injury and safety in New Plymouth District, there are many other injury and safety-related events that do not get recorded routinely on any database and are therefore not available for inclusion in a report such as this.

These events comprise what might be termed the hidden part of the 'injury mountain' – the many thousands of injuries that people throughout the community experience in the course of a year, some of which are simply ignored or left to heal naturally, some of which are self-treated or treated by family or friends, and some of which are seen by health professionals such as general practitioners or physiotherapists but not deemed serious, complex or disabling enough to require emergency department or inpatient hospital treatment, or to trigger receipt of significant ACC insurance entitlements.

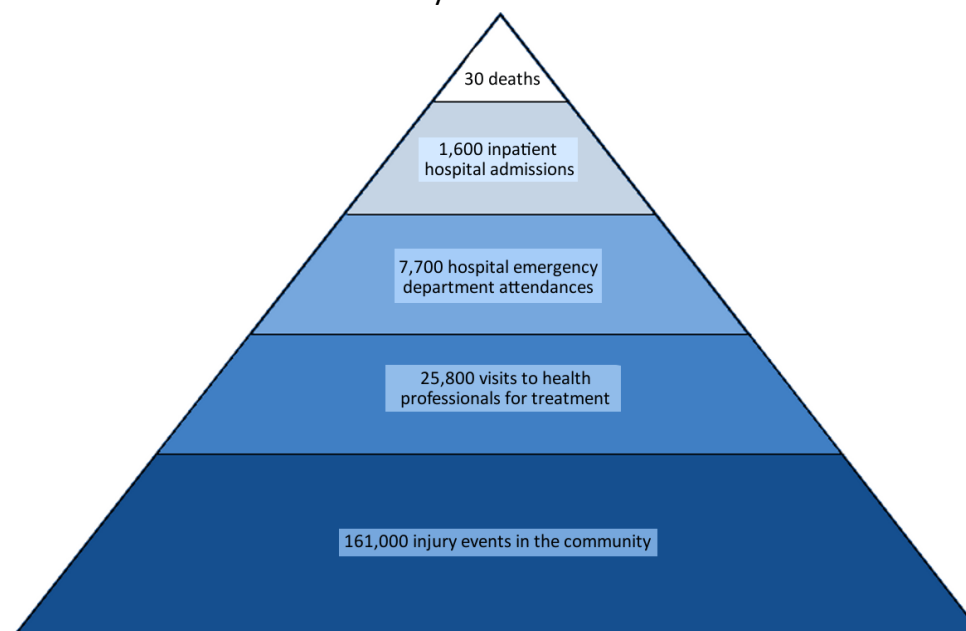
Although no known data is available specifically on New Plymouth's hidden injury mountain, findings from research elsewhere in New Zealand and Australia can be used to develop a rough approximation of its likely size (figure 0.1 below).

Injury trends over time

Injury death rates: Age-standardised injury death rates for New Plymouth District (calculated as 3-year running averages) progressively fell in the nine years from 2000–2008. In addition, New Plymouth's rates (as 3-year running averages) were largely below New Zealand's throughout this period, despite New Zealand's rates also falling (figure 0.2 overleaf).

Injury hospitalisation rates: After being higher than New Zealand's in every year from 1989 to 1998, New Plymouth's all-age injury hospitalisation rates were lower than New Zealand's in every year from 1999 to 2010 except 2009 (figure 0.3 overleaf).

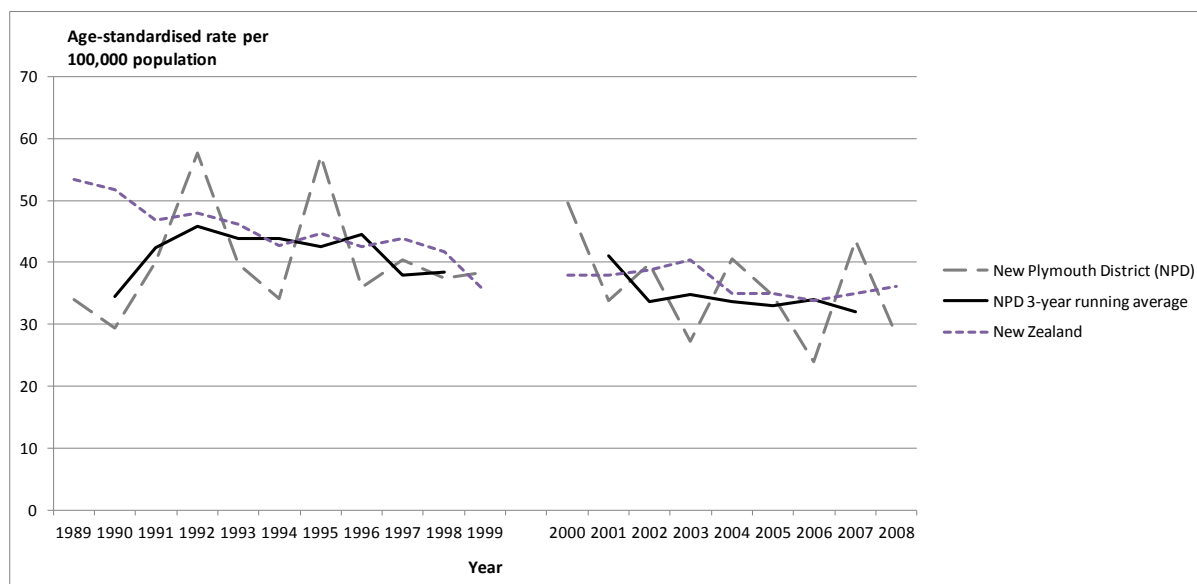
Figure 0.2 Estimated Total Injury Events and Treatments Over 12 Months
New Plymouth District



Source: Estimates calculated by HealthSearch Ltd. based on data from Australian Bureau of Statistics (2006) and data supplied by Ministry of Health and Taranaki District Health Board. Diagram is not to scale.

Figure 0.2

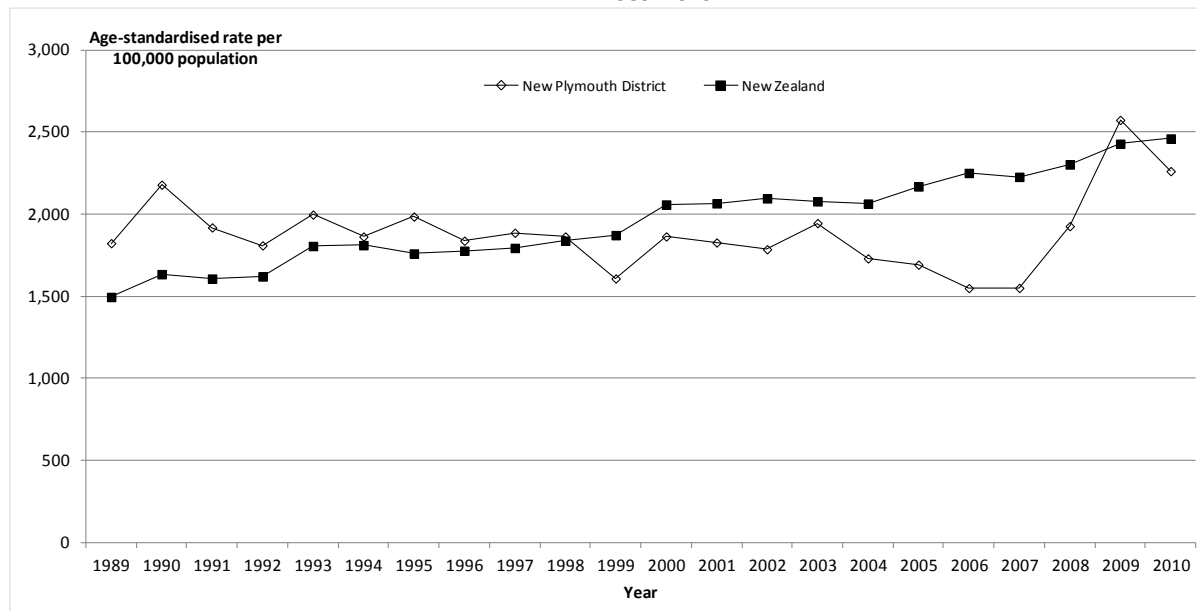
Annual Injury Death Rate
New Plymouth District and New Zealand
1989–1999, 2000–2008



Source: Data supplied by Ministry of Health. **Note:** Years are calendar years 1 January to 31 December. Data for 2008 is provisional. The ICD classification system changed from ICD-9 to ICD-10 in the year 2000.

Figure 0.2

Annual Injury Hospitalisation Rate
New Plymouth District and New Zealand
1989–2010



Source: Data supplied by Ministry of Health. Data in appendix table HS.8. **Note:** Years are calendar years 1 January to 31 December.

Hospitalisation rates for falls: Looking at trends over time for the different causes of injury, in the 10 years 2001–2010, New Plymouth District's age-standardised fall injury hospitalisation rates were notably lower than New Zealand's, especially between 2004 and 2008. Only in 2009 was New Plymouth's rate almost as high as New Zealand's. These trends suggest things have been happening in New Plymouth District in recent years that have made a favourable impact on hospitalisation rates for falls.

Hospitalisation rates for traffic accidents: In every year up to and including 2008, New Plymouth District's rates of traffic accident hospitalisations were lower than New Zealand's. New Plymouth's rate was higher than New Zealand's only in 2009.

Road crashes

There were 172 road injury crashes reported to the Police in New Plymouth District in 2010. A total of 206 people were injured in these crashes including 3 killed and 30 seriously injured. One hundred and seventy-three people received minor injuries.

Generally there was a downward trend in the number of serious or fatal road crashes and casualties in New Plymouth District from 1996 to 2010.

Over the same period, New Plymouth District had a slightly lower proportion of casualties with fatal or serious injuries (17%) compared with New Zealand as a whole and similar-sized towns (Group C) (18% and 21% respectively).

Of the 230 people killed or seriously injured in road crashes in New Plymouth District from 2006–2010, 44% were aged 10–29, and 67% were males.

Quick facts: road crashes and casualties in New Plymouth District

Fatal or serious crashes and casualties, 1996–2010			Injury crashes and casualties, 2006–2010 combined			Injury crashes on urban and rural roads, 2006–2010 combined		
Year	Total fatal or serious crashes	Total fatal or serious casualties		Crashes	Casualties		Total	Percent
			Fatal	27	27	Urban	609	59 %
			Serious	175	203	Rural	417	41 %
1996	53	62	Minor	824	1,128	Age-group of fatal or serious casualties, 2006–2010 combined		
1997	54	60	Total	1,026	1,358			
1998	61	79	Casualties, 2006–2010 combined					
1999	50	58						
2000	41	51						
2001	38	46						
2002	32	35					Male	Female
2003	47	55	Fatal	22	5	10–19	54	23 %
2004	52	70	Serious	131	71	20–29	47	20 %
2005	27	36	Minor	608	517	30–39	28	12 %
2006	37	41	Total*	761	593	40–49	40	17 %
2007	47	53	*total excludes 4 of unknown gender			50–59	22	10 %
2008	45	50		Māori	non-Māori	60–69	13	6 %
2009	43	53	Fatal	15	85	70–79	14	6 %
2010	30	33	Serious	16	77	80+	5	2 %
			Minor	16	73	Unknown	3	1%
			Total*	221	1,007	Total	230	100 %
			*total excludes 130 of unknown ethnicity					

Criminal offences

A total of 5,817 criminal offences were recorded in New Plymouth Police Area in 2010. This included violent offences resulting in injury, as well as other offences that make people feel unsafe like burglary and public disorder.

A total of 736 offences involved direct physical injury from actions such as common assault, serious physical assault, sexual assault and homicide.

Of the 4,026 people apprehended in 2010, 77% were male, 41% were aged 20 or under and 42% were Māori.

From 1994 to 2010, the total number of criminal offences reported in the Police Area dropped 29%, compared with 21% for New Zealand as a whole.

Community consultation

One-to-one interviews were conducted with 11 people from local 'general / health' organisations which deal with injury and safety outcomes or have an overview of injury and safety issues. We also carried out 13 interviews with 'stakeholders' from injury prevention and safety organisations which generally had links with NPiS.

In addition, members of the NPiS Trust itself were surveyed by e-mail (8 respondents). Two focus groups were also conducted with Māori (5 participants) and workplace safety representatives (7 participants).

The five consultation groups were asked some similar, and some different, questions about injury prevention and safety issues in New Plymouth District.

Quick facts: recorded criminal offences in New Plymouth Police Area

Recorded offences, 2010	Offences		Apprehensions for all offences, 2010 by age, gender, ethnic group of offender		
	Total	Percent			
Theft and related offences	1,546	27 %	Age	Total	Percent
Public order offences	803	14 %	0–9	13	<1 %
Property damage and environmental pollution	794	14 %	10–13	141	4 %
Acts intended to cause injury	687	12 %	14–16	490	12 %
Unlawful entry/burglary, break and enter	562	10 %	17–20	1,018	25 %
Illicit drug offences	466	8 %	21–30	1,178	29 %
Offences against justice procedures, government security and government operations	346	6 %	31–50	985	25 %
Fraud, deception and related offences	198	3 %	51+	201	5 %
Abduction, harassment and other related offences against a person	183	3 %	Total	4,026	100 %
Prohibited and regulated weapons and explosives offences	125	2 %	Gender	Total	Percent
			Male	3,088	77 %
			Female	930	23 %
			Unknown	8	<1 %
			Ethnic group	Total	Percent
Sexual assault and related offences	48	1 %	Māori	1,672	42 %
Robbery, extortion and related offences	26	0 %	non-Māori	2,326	58 %
			Unknown	28	<1 %
Dangerous or negligent acts endangering persons	13	0 %			
Homicide and related offences	1	0 %			
Miscellaneous offences	18	0 %			
Total	5,817	100 %			

Community consultation: Identified injury prevention and safety issues

General / health interviewees	Māori focus group	Workplace focus group
<u>Perceived changes in injury and prevention safety issues in last 10 years</u> All injuries ↓ Unintentional injuries ↓ Alcohol and drugs ↑ ↓ Road safety ↑ ↓ Assaults ↑ ↓ Family violence ↑ Workplace ↑ Sports / recreation ↑ Home ↑ Rural / farms ↑ ↓ Children / young people ↑ ↓ Middle-aged people ↑ Older people ↑ ↓ Māori ↑ Injury prevention awareness ↑	<u>Significant existing issues</u> Water safety Road-related injuries Family violence in conjunction with alcohol and drugs <u>Issues getting worse / future issues</u> Fighting by young people Child neglect and abuse Child day-care accidents Older people falls Sports injuries Work-related	<u>Significant existing issues</u> Lack of safety training Lack of job fitness Workforce diversity Hazards related to specific jobs Wider lifestyle, health and economic issues from outside work <u>Issues getting worse / future issues</u> Communication and cultural issues for new-immigrant workers People working from own home and at other people's homes Allergies Poor diets Sports injuries Ageing population

↑ = perceived increase

↓ = perceived decrease

↑ ↓ = perceived increase for some issues, decrease in others

Local community injury and safety programmes

Stakeholders and general / health interviewees were aware of, and ran, a very wide range of local community injury and safety projects and programmes. Many of these programmes were seen as effective in what they were trying to achieve although a few suggestions were made for improving some of them.

The Māori focus group listed several Māori-specific initiatives but said the range of these had decreased recently. They observed that no progress had been made to date on any of the three key recommendations of the *Poututangata: Maori and Injury Community Action Research* report. Probably, if anything, the situation had worsened with the loss of a very capable and well-respected community worker who had left to take up a position outside the region (this person was also an NPiS Trust member).

Awareness of NPiS / the Safe Community

There was a high level of awareness of NPiS in all the consultation groups, apart from the Māori focus group. There was also a high level of awareness of the Safe Community, apart from the workplace focus group.

Role of NPiS / the Safe Community

The general / health interviewees were usually able to describe the role of NPiS / the Safe Community. The most commonly-described features were collaboration / a coalition / a partnership / intersectoral group; work to reduce injury / create a safe environment; Safe Community activities.

Impact of NPiS / the Safe Community

Most (11 of the 13) stakeholders thought that NPiS / the Safe Community had made a positive difference in preventing injury and promoting safety locally. Seven of the 11 general / health interviewees agreed, as did seven of the eight NPiS members.

The most commonly-described impacts of NPIS / the Safe Community were:

- promoting networks, collaboration and partnerships between organisations and groups
- providing education, information and publicity
- developing and maintaining the Safe Community
- identifying gaps and priorities, promoting evidence-based action.

Most of the participants in the two focus groups believed they did not know enough about NPIS or the Safe Community to comment on their impact.

Programme manager

The NPIS / Safe Community programme manager who had been employed by NPIS in 2007, resigned at the end of 2010 because of the lack of certainty about ongoing funding for her position.

Having a programme manager was seen as 'absolutely essential' by six of the NPIS Trust members and 'very important' by two. The programme manager's main roles were similar to those described above for NPIS / the Safe Community i.e. networking / partnership building, publicity / raising awareness of injury prevention and safety issues; identifying gaps in programmes and supporting groups to develop and run programmes.

Many consultation interviewees made positive comments about how the programme manager had operated. When directly asked, 10 of the 13 stakeholders said they thought there had been a noticeable reduction in the effectiveness of some community injury prevention and safety programmes since she had left.

NPIS Trust members also described the difficulties of working without a programme manager, although Trust members said they had managed to achieve quite a lot without her in 2011. This was mainly because a few members of the Trust had taken over many of her duties – a situation they did not see as sustainable.

Website

Eleven of the 24 general / health and stakeholder interviewees had visited the Safe Community website. This was mainly to access documents or keep up to date with issues.

Those who had visited the website were generally satisfied with it and found it useful. Just a few criticisms were made – mainly to do with the website's design and ease of navigation. Most of the NPIS Trust members (six of eight) were also satisfied with the website.

Suggested improvements were to make sure the website was kept up to date, encourage people to use it and redesign its home page.

Newsletter

All but two of the 24 general / health and stakeholder interviewees had read NPIS's newsletter at least once. Eight usually read the whole newsletter every month and a further nine looked at it each month to read items of interest. People liked the newsletter because it was brief (one page), 'easy to read', 'chatty', 'newsy', 'engaging' and kept them up to date. The main criticism was its lack of relevance to some people's work.

Seven of the eight NPIS Trust members were satisfied with the newsletter.

There were a few suggested improvements, mainly related to the newsletter's design and distribution.

Other things NPIS / the Safe Community can do

The most common suggestion from stakeholders and general / health interviewees was that NPIS / the Safe Community should employ a new programme manager, although this was seen as difficult because of resource limitations.

The NPIS Trust

NPIS Trust members were asked for their opinions about how the Trust operates. They believed the Trust's most important functions were along the lines described for NPIS / the Safe Community (see above), with the addition of employing a programme manager and obtaining funding to do so.

All eight NPIS Trust members said their employing organisation benefited from belonging to the Trust. This was mainly because a reduction in injuries and other safety-related outcomes would put less pressure on their organisation to deal with them. While there were costs to belonging to the Trust in terms of time, funding and other resources, the view was that these costs were reasonable for the returns gained.

Most Trust members did not think additional organisations should be represented on the Trust, primarily because they believed there was already good community representation and having extra members may become unmanageable.

When asked if the Trust members had a shared vision of what they were trying to achieve, half said they did and half said they sometimes did.

The Trust's move to a wider focus (from injury to wider safety issues) was causing some tension. However, most (seven) of the Trust members thought they generally worked well together. Most (five) also thought they communicated well with one another and three said they 'sometimes' did. All eight Trust members thought their meetings were well-run and useful.

Three thought they worked well with Māori and four said they did 'sometimes'. There were several suggestions that they should try to find ways of reducing injury among Māori.

The area of most dissatisfaction was the process of getting funding – only one member was satisfied with this aspect of the Trust's operation. Four said the processes for obtaining funding sometimes worked well and three said they did not work well. They said the main problem was ACC's withdrawal of funding for employing the programme manager and the Trust's inability so far to replace this funding with another source. (Note that in December 2011 ACC announced a new funding formula for Safe Communities that NPIS potentially could use to employ a new programme manager).

The future of the Trust was seen by its members to be continuing with their current role of co-ordinating community injury prevention and

safety programmes, and becoming more pro-active in raising community awareness of injury and safety issues. They also thought they would have to be sensitive to funders' expectations and requirements.

Getting funding to employ a new programme manager was most commonly seen as the next step the Trust needed to make.

Feedback on the draft Community Safety Strategy

The majority of people taking part in the interviews and focus groups believed the idea of a community safety strategy was a good one.

However, their initial reactions to the draft strategy were mixed. Several people remarked that they liked the strategy's clear and comparatively simple layout, and its relative ease of understanding.

Others considered the content to be expressed at such a high level of abstraction and generality that it lacked scope for practical application. In general, the workplace focus group thought the draft strategy was too 'wordy'.

A few interviewees had reservations about what they saw as the strategy's unrealistic and 'utopian' goals; objectives that were too idealistic and impossible to achieve. Some people wanted to see more explicit statements of action in the strategy, even to the point of defining clear outcome measures that could be evaluated.

Another common observation from interviewees was that the strategy lacked a clear statement of responsiveness to Māori. Members of the Māori focus group queried the level of Māori input into the draft strategy to date and noted the absence of Māori concepts and Te Reo. They contended that alongside or within the strategy there was a need to develop a Māori-specific strategic plan focusing on issues affecting Māori in the district. One suggestion was to have a Maori action plan for each of the strategy's eight priority areas.

Despite these misgivings, nine of the 13 stakeholders and seven of the 11 general / health interviewees thought the strategy would be

effective in contributing to a safer New Plymouth District.

In terms of their importance, the general / health and stakeholder interviewees ranked the eight priorities as follows:

1st	Alcohol
2nd	Family violence
3rd=	Crime prevention
3rd=	Injury prevention
5th	Road safety
6th	Workplace safety
7th=	Emergency management
7th=	Secure and Healthy Homes

A small number of people thought that Secure and Health Homes, Emergency Management or Crime Prevention should be excluded as priorities.

Māori, sports / recreation, older people and child safety were suggested by a few people as priority areas that could be added.

The interviewees and the focus groups made a number of suggestions for improving the wording of the eight priorities. One of the most common specific suggestions was that the 'alcohol' priority should be renamed 'alcohol and drugs' (although, for resourcing reasons, the wisdom of including drugs was questioned by one person).

The workplace focus group thought the term 'zero harm' for the workplace programme response was unrealistic. The wording of two of the strategic goals (the second and third) also attracted criticism from some of the general / health and stakeholder interviewees.

Quick facts: the people of New Plymouth District

Total population <i>2006 Census</i>				Estimated 2011 population <i>based on 2006 Census</i>		Māori population <i>2006 Census</i>			
	<i>Male</i>	<i>Female</i>	<i>Total</i>				<i>Male</i>	<i>Female</i>	<i>Total</i>
<i>Age</i>				72,300		<i>Age</i>			
0–4	2,226	2,010	4,236	Total households (private dwellings)		0–4	552	519	1,071
5–9	2,472	2,292	4,764	<i>2006 Census</i>		5–9	618	519	1,134
10–14	2,724	2,628	5,352	26,508		10–14	585	528	1,118
15–19	2,595	2,436	5,031	Urban / rural		15–19	552	483	1,035
20–24	1,875	1,740	3,615	Nearly 3/4 (72%) of residents live in		20–24	345	333	681
25–29	1,755	1,827	3,582	urban and suburban areas of New		25–29	315	321	639
30–34	2,001	2,313	4,314	Plymouth City.		30–34	312	321	633
35–39	2,247	2,547	4,794	Another 14% live in the city's		35–39	297	318	615
40–44	2,505	2,724	5,226	satellite urban areas of Waitara and		40–44	303	318	618
45–49	2,460	2,739	5,196	Inglewood.		45–49	261	279	537
50–54	2,259	2,328	4,584	Just 15% live in rural areas.		50–54	192	189	384
55–59	2,139	2,193	4,332			55–59	138	153	291
60–64	1,641	1,638	3,279	Most common industries - men		60–64	102	102	201
65–69	1,356	1,500	2,859	<i>2006 Census – employed males</i>		65–69	84	84	165
70–74	1,188	1,287	2,475	Manufacturing	16 %	70–74	48	60	111
75–79	1,011	1,278	2,289	Construction	13 %	75–79	33	45	78
80–84	636	1,023	1,659	Agriculture / fishing	9 %	80–84	12	21	36
85+	429	885	1,314	Retail	8 %	85+	12	18	24
Total	33,510	35,388	68,901	Professional, scientific, tech	7 %	Total	4,761	4,608	9,369
Total children, adults, older persons <i>2006 Census</i>				Most common industries - women		No access to a motor vehicle <i>2006 Census</i>			
Children (0–14)			14,352	<i>2006 Census – employed females</i>		8 % of people			
Adults working age (15–64)			43,953	Health care, social assistance	18%				
Older persons			9,906	Retail	13%				
				Education and training	12%				
				Accommodation , food services	8%				
				Professional, scientific, tech	7%				

INTRODUCTION

This is the third community injury prevention needs assessment report for New Plymouth District. It follows on from the first report in 2001 and the second in 2006 (McClellan et al 2001, 2006).

The report has two objectives.

The first is to provide New Plymouth injury Safe (NPiS) with detailed up-to-date statistics on injury patterns, and injury and safety-related risk factors in New Plymouth District. This is intended to be a core resource to help underpin and guide the development of injury prevention and safety strategies and projects in the district over the next five years.

The second objective is to endeavour to assess the impact New Plymouth injury Safe has made on the way injury and safety issues are addressed by organisations and people in New Plymouth District. This is primarily an evaluation exercise rather than a straight reporting of statistics, relying on qualitative evidence gathered from a range of New Plymouth people supplemented by a review of injury trends and other relevant research material.

Report structure

Chapter 1 provides an overview of the development and operation of New Plymouth Injury Safe (NPiS). This concentrates mainly on the five years since the last needs assessment was completed in 2006. It is based largely on a review of published reports and documents produced by NPiS and other injury prevention and safety organisations.

Chapter 2 summarises the latest available socio-demographic statistics for New Plymouth District. This looks at the population's age, gender and ethnic profile, educational qualifications, employment, main industries and occupations, income and levels of socio-economic deprivation. Most of this data comes from the 2006 NZ Census of Population and Dwellings.

Chapters 3 to 10 describe the latest available injury and safety-related statistics for the district, drawn from various sources. They include:

- injury deaths (mortality data), obtained from the Ministry of Health (chapter 3)
- inpatient hospitalisations for injury, obtained from the Ministry of Health (chapter 4)
- hospital emergency department attendances for injury, obtained from the Taranaki District Health Board (chapter 5)

- insurance claims for injury, obtained from the Accident Compensation Corporation (chapter 6)
- road injury crashes and casualties, obtained from the NZ Transport Authority (chapter 7)
- suicide deaths, obtained from the Ministry of Justice's Coronial Services Unit (chapter 8)
- drowning deaths, obtained from Water Safety NZ (chapter 9)
- criminal offences including violent offences, obtained from NZ Police data on the Statistics New Zealand website (chapter 10).

Chapter 11 presents the results of the consultation interviews conducted for the needs assessment. These interviews were one-to-one, face-to-face interviews with people from organisations running collaborative injury prevention or safety promotion initiatives in the district, and people from local services that routinely treat or in other ways deal with the impacts of injury (e.g, ambulance service, ACC, hospital emergency department, primary health organisations, etc.). It also includes information from an email survey of NPiS Trust members.

Chapter 12 presents the findings of a Māori consultation focus group. This focus group was run in an effort to ensure that, as tangata whenua, Māori views and voices were heard and taken account of during the needs assessment.

Chapter 13 presents the findings of a second consultation focus group, this time covering the topic of workplace safety. Members of the NPiS Trust group were interested in examining this topic in more depth as they recognise workplaces as important channels to communicate with and influence a large sector of the community. They also felt the community could learn from the strong workplace safety culture that exists in Taranaki.

The final chapter, chapter 14, revisits key statistics and consultation feedback from earlier sections to discuss and offer conclusions on some of the more prominent injury and safety issues in New Plymouth District. As well, it synthesises and comments further on aspects of the consultation feedback addressing the accomplishments and impact of NPiS and the wider New Plymouth Safe Community. This includes noting possible future strategies and directions for the work of NPiS and the Safe Community. The discussion is set in the context of international and national research studies and other reports on community injury prevention and safety.

Accompanying this report are two stand-alone volumes of appendices.

Appendix Volume One contains the full set of statistical tables prepared by HealthSearch Ltd for the needs assessment. References to individual appendix tables are included throughout the report for readers wanting to examine the data on a particular topic, or for a particular chart, in detail.

Appendix Volume 2 contains copies of the questionnaires, interview guides and other documentation used for the community consultation phase of the needs assessment.

Statistics methodology

Data was obtained from published sources on the internet or was ordered and obtained as customised datasets from various agencies (see above). The data was then transferred to Excel spreadsheets and analysed using this software. Where numbers were too small for analysis, data were aggregated. Where possible, the data was analysed by age, gender, ethnicity and other suitable demographic categories. Age-specific and age-standardised rates were also calculated where numbers allowed.

Charts illustrating key data are presented throughout the text. This includes charts tracing trends over time where adequate data is available for several consecutive years. A complete set of tables showing all data analysed for the report is in Appendix Volume One.

Confidence intervals and other measures of statistical reliability or significance were not calculated for the purposes of this report.

Consultation methodology

The community consultation phase of the needs assessment consisted of one-to-one, face-to-face interviews, focus-group discussions and email questionnaires. The aim of the consultation was to find out what people considered to be the main injury issues or problems currently confronting the New Plymouth population and the best ways to address them. The consultation also examined people's awareness of NPiS and their views on the appropriateness and impact of various NPiS injury and safety initiatives. In addition, feedback was gathered on a draft New Plymouth District Community Safety Strategy (New Plymouth District Council / New Plymouth injury Safe 2011).

Interviews

Face-to-face Interviews were conducted with a selection of people from organisations running injury prevention or safety promotion initiatives in the district, and people from local services that routinely treat or in other ways deal with the impacts of injury. Potential people to interview were identified on the advice of NPiS Trust members, with the aim of obtaining a good cross-section of views and experiences.

Letters and e-mails were sent to these people inviting them to participate in a 60 minute interview with a researcher (either Velma McClellan or Caroline Maskill). All of these people agreed to be interviewed, and were contacted to arrange a suitable interview time and venue.

The interviews were structured around a standard set of topics and questions developed in consultation with NPiS Trust members. Different questions were asked in parts of the interview depending on whether a person was from an organisation running prevention initiatives or from an injury treatment service (see Appendix Volume Two for copies of the interview schedules used).

In general, the first half of the interviews focused on defining what people considered to be the main injury issues affecting the New Plymouth population and ways to respond to these issues. The second half encouraged people to talk openly about their awareness and perceptions of the work

of NPiS and the wider New Plymouth Safe Community initiative, as well as identify any problem areas or ways the future work of these could be improved.

The interviews were recorded using note-taking and a digital audio recorder (the latter used with the consent of the interviewee). Altogether, in the second half of October of 2011, 14 'stakeholders' from different local organisations running injury prevention or safety programmes were interviewed (one interview included two people). An additional 11 people were interviewed from 'general or health' organisations which dealt with injury outcomes or had an overview of local safety issues.

NPiS survey

In November and December of 2011, eight members of the NPiS Trust group completed an email questionnaire covering similar topics to those covered in the interviews, plus additional questions more directly related to the operation and impact of NPiS (see Appendix Volume Two for a copy of the email questionnaire).

Māori focus group

The Māori consultation focus group was held in February 2012 in New Plymouth, facilitated by Caroline Maskill with the assistance of Velma McClellan. A list of possible participants for the focus group was identified by NPiS Trust members in conjunction with Lyn Hoskin of Tui Ora Ltd, who organised the group. Altogether eight people agreed to participate in the group, with five people attending on the day.

During the group discussion people were asked to comment on a range of topics including what they perceived to be locally-significant injury prevention and safety issues for Māori (current and future) and features of local initiatives addressing these issues. They were also asked to comment on how NPiS and the broader New Plymouth Safe Community currently functions in relation to injury prevention and safety for Māori, and suggest future possible ways NPiS and the Safe Community could support local efforts to promote Māori injury prevention and safety.

In addition, the group was invited to comment on the draft New Plymouth District Community Safety Strategy, particularly in relation to safety issues for Māori.

The focus group ran for over two hours and included a catered lunch. Written notes were taken by the researchers and the session was also audio-recorded.

As requested by the participants, once the researchers had written up the focus group results in draft form, copies were sent to participants for checking.

Workplace focus group

The second consultation focus group, covering the topic of workplace safety, was also held in February 2012. This group consisted of seven representatives with an interest in workplace safety from a range of industries. Once again potential participants for the group were identified by Trust members, with the session facilitated by Caroline Maskill with support from Velma McClellan.

Guided by a topic list developed in conjunction with NPiS, participants were encouraged to highlight and discuss locally-significant workplace injury prevention and safety issues. This included discussing how NPiS and the broader New Plymouth Safe Community currently functions in relation to workplace injury prevention and safety. Participants were then asked to suggest possible ways that NPiS and the Safe Community could support local efforts to promote workplace safety. In the last part of the discussion participants were invited to comment on the draft Community Safety Strategy, particularly as it pertained to workplace safety.

The workplace group ran for just over an hour and a half. The researchers made written notes during the session and the discussion was also audio-recorded.

Consultation analysis

The interviews and email questionnaires were analysed by going through each of them individually and collating the specific information and ideas given by people under each of the topic headings and questions. This included counting up how many interviewees mentioned certain ideas or viewpoints.

Similarly, the focus group material was analysed by reviewing notes and audiotapes to identify themes. Notes from an exercise during the session where participants wrote on a large sheet of paper were also included in the analysis. Results for the group are reported as a whole, as it was not possible to document how many people agreed or disagreed with every idea the group discussed.

Limitations of the needs assessment

Readers should note the following potential limitations of the needs assessment, based as it is mainly on an analysis of existing statistics and consultation with local injury prevention and safety organisations.

For one thing, the reporting of injury and safety statistics is fundamentally dependent on their availability (not to mention other key elements such as timeliness). If local statistics are not available for a specific injury or safety topic, then that topic by definition will receive little prominence in a report such as this, at least in terms of being highlighted in tables, charts and associated commentary. This does not necessarily mean the topic is unimportant. It just means the topic has not yet attracted sufficient attention or resources for numerical data to be gathered on it routinely.

Moreover, even when up-to-date statistics are available relevant to a particular injury or safety issue, there is still no guarantee the statistics will portray a totally unambiguous picture of the issue in question. Rather, they will almost always need to be carefully and cautiously interpreted.

As later sections of this report show, most of New Zealand's standard injury datasets are drawn from administrative or patient records collected by hospitals or other injury treatment services. They therefore do not record the total incidence or prevalence of injury-related events in the community, they simply record the number and types of cases coming to the attention of a

particular service. In this respect, it is important to remember that changes in admission policies or treatment thresholds, or changes in the resources allocated to certain services, as well as a host of other factors (e.g. people's ability to access services), can influence how many injury cases turn out to be accepted or seen by a particular service.

On top of this, problems with the completeness or variability of systems used to collect and classify data on individual service users can also reduce the reliability of injury and safety statistics.¹ This can be especially problematic when trying to get an accurate idea of whether or not volumes or rates of treatment for certain injuries have changed from year to year.

Regarding the methods used to do the community consultation, it should be emphasised that the people invited to be interviewed or attend focus groups were selected on the advice of NPiS. The consultee group was therefore a purposive sample rather than a strictly random or representative sample. Efforts were made to recruit people who had contrasting or minority viewpoints. However, it is possible that a larger study involving a wider selection of people from local agencies, as well as perhaps interested members of the public, might have yielded a slightly richer or more diverse array of ideas and comment on certain issues. On the other hand, a larger study would have required more funding and time to execute (both of which were limited), with no assurance it would add anything new or valuable compared with the current approach.

Another potential limitation of the consultation approach is its reliance on researcher note-taking for recording people's ideas and information. Some details of what people said arguably may have been lost or misreported. Nonetheless, the researchers who carried out the consultation interviews and focus groups were both very experienced. Audio-recordings of the interviews and focus groups were also checked where there were concerns about the reliability of any written notes.

¹ There is a substantial international literature examining the accuracy of injury data obtained from administrative records. For analyses of New Zealand data see for example Cryer, Gulliver et al (2011), Cryer, Fingerhut et al (2011), Davie et al (2008), and Langley et al (2006, 2007).

1

NEW PLYMOUTH INJURY SAFE: DEVELOPMENTS AND ACTIVITIES 2006–2011

New Plymouth Injury Safe (NPiS) is a coalition of people with links to a range of organisations and groups in New Plymouth District with a stake in injury prevention and community safety.

This chapter presents an overview and discussion of key features of the NPiS initiative. This includes outlining the wider national and international context of community-based injury prevention of which NPiS is a part, as well as looking at the governance structures and planning processes NPiS uses to organise and deliver its activities. Examples are also given of the range of injury prevention projects and programmes that NPiS has had a key role in developing, supporting and/or running.

In terms of timeframes, the chapter focuses largely on NPiS activities over the past five years, as the previous 2006 needs assessment report covered developments prior to this (McClellan et al 2006).

The content of the chapter is a synthesis of information gleaned from evaluation reports, strategy statements, meeting minutes, Safe Community accreditation applications and other documentation prepared by NPiS (e.g. New Plymouth Injury Safe n.d, 2010, 2010a) supplemented by material from the wider safe community literature.

Above all, the chapter aims to provide a chronological outline of the development, goals and activities of NPiS, to assist readers to better interpret the injury statistics and community consultation findings presented later in the report.

Development of the New Plymouth injury Safe initiative

NPiS's origins can be traced to a serendipitous alignment of international, national and local public health initiatives and personnel. In 2000, several organisations and groups with an interest in aspects of injury prevention and community safety were operating in the New Plymouth District. However, there were relatively few sustained collaborative links between them.

Around this time, developments in public health theory and practice were emphasising the potential value of intersectoral collaboration and coalition building between diverse agencies and

sectors to address health problems. In the area of injury, the concept of building partnerships between local people and organisations to improve the effectiveness of injury prevention and safety promotion activities was being promoted internationally by the World Health Organization through its Safe Communities model. Developed in Sweden in the 1970s and promulgated widely by the WHO Collaborating Centre on Community Safety Promotion at Stockholm's Karolinska Institutet, this model aims to reduce injuries not through centralised, top-down approaches such as laws or regulations, but by mobilising local organisations and groups in a city, town, region or district and encouraging them to work together.

In New Zealand, guided by the WHO model, in 1994 the then Public Health Commission, a central government agency, funded five pilot community injury prevention projects in selected cities and districts. A common feature of each of these projects was the setting up of an intersectoral advisory group consisting of representatives from local organisations and groups with a stake in injury prevention. In addition, working groups were established to identify and plan suitable local initiatives to address particular kinds of injuries. Full or part-time programme co-ordinators were also appointed to provide administrative support and help implement the new injury prevention initiatives identified.

Two of these pilot projects, one in Waitakere City and one in Waimakariri District in North Canterbury, were particularly successful. They became recognised as models for how to develop and sustain a local, collaboratively-based, intersectoral injury prevention initiative in New Zealand.

Although the Public Health Commission was disestablished officially in 1996, central government responsibility for funding the initiatives was taken over by the then four Regional Health Authorities.² and the Accident Compensation Corporation. In 1999, the Waitakere programme ('Safe Waitakere') and the Waimakariri programme ('Injury Prevention Waimakariri') were both formally designated as World Health Organization safe communities.

2001–2005

Encouraged by the success of the Waitakere and Waimakariri projects, in 2001 the Accident Compensation Corporation (ACC) made funds available to support initial planning and consultation work in other New Zealand communities wishing to consider setting up a local injury prevention project.

In New Plymouth, staff from various local health and social service agencies, including Tui Ora (a Māori development organisation providing public health services), Taranaki Health Promotion (the Health Promotion Unit of Taranaki Health), Kidsafe Taranaki, the community development section of New Plymouth District Council, the local Plunket Society (an agency providing health and support for new mothers and their babies), and the local office of ACC, met to discuss the opportunity the funding presented for developing new local strategies to address injury in the district.

² The Waitakere initiative was also funded in part by the Accident Compensation Corporation during this period.

Later in 2001, with Tui Ora as the lead agency, the group, calling itself the New Plymouth District Injury Safe Advisory Group, successfully applied to ACC for funding to undertake an injury prevention needs assessment in the district. The intention was that the needs assessment would provide a starting point and catalyst for the Injury Safe Advisory Group and other interested people and organisations to further discuss and agree on priorities for the work of a cross-sectoral, collaborative injury prevention initiative in the district. The needs assessment compiled and analysed New Plymouth and national injury statistics, and consulted local organisations and people about the district's injury prevention priorities and the potential for working more collaboratively.

The final report of the needs assessment (McClellan et al 2001) identified five injury priority areas for intersectoral action in the district: falls among older people, children's falls, youth road safety and violence, injuries to Māori, and farm injuries. The Injury Safe Advisory Group then ran networking meetings in the community to publicise and build support for the priorities and encourage local agencies and groups to think about the kinds of joint action they could take to address them.

Out of this, in 2002, came agreement by representatives from a number of agencies and groups in the district to join together to form New Plymouth injury Safe (NPiS); a collaborative, inter-sectoral community injury prevention initiative. Soon after this, New Plymouth District was selected as a site for one of ACC's 23 new ThinkSafe Community Projects. This meant NPiS was able to obtain financial and technical assistance from ACC to support its activities, with the focus of its work continuing to be the five priority areas identified in the needs assessment but with the addition of workplace injuries as a sixth priority.

Around this time, at a national level, NPiS's work gained further impetus and support through the introduction of several government-led strategies and initiatives. These included the New Zealand Injury Prevention Strategy (NZIPS) released in 2003, which aimed to better co-ordinate injury prevention activities across government agencies. The strategy identified six injury priority areas: motor vehicle traffic crashes; suicide and deliberate self-harm; falls; assault; workplace injuries; and drowning (NZIPS Secretariat 2010, Wren and Barrell 2010). Subsequent national strategy documents outlined key goals and actions for each of the six priority areas.³

³ Strategy documents include:

- Safer Journeys: New Zealand's Road Safety Strategy 2010–2020 (National Road Safety Committee 2010)
- Drowning Prevention Strategy: Towards a Water Safe New Zealand 2005–2015 (Dyson 2005)
- Workplace Health and Safety Strategy for New Zealand to 2015 (Dyson 2005a)
- Preventing Injuries from Falls: the National Strategy 2005–2015 (Dyson 2005b)
- New Zealand Suicide Prevention Strategy 2006–2016 (Associate Minister of Health 2006)
- Te Rito: New Zealand Family Violence Prevention Strategy (Family Violence Focus Group 2002)
- Taskforce for Action on Violence within Families (Ministry of Social Development 2006, 2007)
- Taskforce for Action on Sexual Violence (Ministry of Justice 2009).

In 2004, with funding support from ACC, the Safe Communities Foundation New Zealand (SCFNZ) was established (UMR Research 2009). A key goal of the foundation was to promote the development of collaborative injury prevention and safe community projects across the country and support New Zealand cities, towns or districts wishing to become formally designated as 'WHO Safe Communities' (now known as 'International Safe Communities').

Early in 2005, with the NPiS group established as a recognised mechanism for uniting a range of local agencies under the injury prevention umbrella, the New Plymouth District Council and NPiS formally agreed to work together to jointly submit an application for the district to become officially accredited as a WHO safe community. Criteria for becoming an accredited safe community include having an infrastructure governed by a cross-sectoral group and running long-term, sustainable injury prevention programmes covering all genders, ages, environments and situations. The safe community model also emphasises the importance of local government involvement in the development and running of community-based injury prevention and safety initiatives.

In mid-September 2005 a panel of experts, invited by Safe Communities Foundation New Zealand (SCFNZ), made a site visit to New Plymouth and on 27 October 2005 the district was officially designated the 95th WHO Safe Community. New Plymouth was the third New Zealand community to be designated as a WHO Safe Community (after Waitakere and Waimakariri), and was the first community to be accredited by SCFNZ.

2006

In 2006, NPiS's second community injury needs assessment was completed (McClellan et al 2006). Findings from this helped pave the way for further developments in NPiS's work.

At the time of the second needs assessment, funding and resources to support NPiS's activities largely came from grants provided by agencies such as ACC, Ministry of Health, Tui Ora Ltd, and Land Transport New Zealand. In addition, several people sitting on the core NPiS co-ordinating group were employed locally in organisations such as ACC, Taranaki DHB, New Plymouth District Council and Tui Ora. Participation in the NPiS group was seen as an appropriate function of these people's roles. Significant additional time was also given to the initiative by staff from local organisations like the Police, Fire Service, Plunket, Department of Labour, and Occupational Safety and Health. As well, other organisations and businesses provided one-off sponsorships or gave in-kind contributions such as discounted or free products and equipment for specific projects.

Despite this important financial and in-kind support from a range of sources, the 2006 assessment identified a pressing need for NPiS to recruit a full or part-time NPiS co-ordinator / programme manager. Having such a person would bring NPiS into line with other long-running safe community initiatives, both in New Zealand and overseas, where individuals are employed specifically to build collaborative relationships between local organisations and co-ordinate the design and delivery of intersectoral projects and programmes.

In June 2006 the NPiS coalition officially became a registered charitable trust, making it legally possible for it to employ people. Later that year it was decided to publicly advertise for a suitable person and in January 2007 a programme co-ordinator began full-time work (4 days per week). Joint funding for this initially three-year position came from ACC and Taranaki District Health Board with each agency providing \$20,000 annually to cover the co-ordinator's salary and a small operating budget. Additional funds to support the first 12 months of the programme manager's appointment also came from Kidsafe Taranaki Trust and Tui Ora Ltd.⁴ The programme manager's office was situated in the Public Health Unit of the Taranaki District Health Board.

Being employed directly by the NPiS Trust meant the programme manager was in a slightly different employment relationship compared to safe community programme managers and co-ordinators in other regions of New Zealand. Typically, safe community co-ordinators or programme managers are employed directly by one of the agencies in the safe community coalition, such as a district or city council or the district health board. However, being employed directly by the NPiS Trust arguably provided the programme manager with more scope for independent action and speaking out on local issues.

The impression given in the public documents, minutes of meetings and other sundry communications produced by NPiS since 2007 is that the new programme manager became a vital contributor to advancing NPiS's work. In particular, she frequently took responsibility for planning and co-ordinating the delivery of one-off and ongoing injury prevention projects, preparing research reports and strategy documents, writing funding applications, and preparing publicity material.

Over this period, members of the NPiS Trust core group continued to take responsibility for a range of governance, co-ordination and advisory functions. This included participating in the monthly early morning meetings of the Trust, where issues related to management of the Trust, work of the programme manager and the broader Safe Community were raised and discussed, and where approvals were given for financial expenditure and other related matters. Aside from these meetings, Trust members also assisted with other vital elements of NPiS's work including networking with other injury prevention and safety promotion partners in the district, contributing to the writing of strategy documents and other reports, preparing funding applications, helping with the running of NPiS-led injury prevention projects, and representing NPiS at community gatherings and other public events.

2007–2011

In looking more closely at NPiS's activities in the last five years (2007–2011), it is useful to distinguish between:

⁴ Funding from New Plymouth District Council was for project delivery only. It was not to be used for the programme manager's position or for co-ordination of projects.

- activities more closely allied to building and maintaining New Plymouth District as a designated International Safe Community,
- activities centred on providing locally-relevant information on injury prevention needs, priorities and programmes
- activities more directly focused on developing and supporting specific one-off and ongoing collaborative injury prevention projects and programmes.

Maintaining New Plymouth District as a designated International Safe Community

The concept of the New Plymouth Safe Community encompasses the totality of injury prevention and safety programmes and projects in the district that involve some degree of inter-agency collaboration or intersectoral working. At any one time there may be dozens of such programmes or projects actively being delivered in the district.

As already noted, the core NPIS coalition group, now legally constituted as a charitable trust, has played a pivotal co-ordination and leadership role in developing New Plymouth District as a WHO / International Safe Community. This includes gaining agreement, through consultation with a wide range of local agencies and groups, that the WHO collaborative model is suitable for application in the New Plymouth District. It includes, too, ensuring that the many different agencies and people funding and/or delivering injury and safety projects in the district are happy to have their particular project included under the Safe Community umbrella. More specifically, leading the development of the Safe Community concept in the district has seen NPIS take responsibility for a good deal of cross-sectoral and inter-agency information sharing and networking, strategic planning, research and report writing.

Examples of this include the significant work put in by Trust members and the NPIS programme manager in 2010 to prepare New Plymouth District's application for re-accreditation as an International Safe Community. This involved writing a substantial document detailing all the injury prevention and safety projects and programmes currently delivered in the district, as well as summarising injury statistics and other relevant data (New Plymouth injury Safe 2010, 2010a). The application for re-accreditation was successful, making New Plymouth District the first Safe Community to be redesignated by Safe Communities Foundation New Zealand. A formal re-designation ceremony was held on 3 September 2010.

Other substantial work by NPIS associated with promoting International Safe Community principles in the district includes preparing high-level strategic planning documents. Typically the documents are developed using the findings of local needs assessments, other research and direct community consultation, as well as being guided by national-level strategies such the New Zealand Injury Prevention Strategy. NPIS's three-yearly strategic plans (the most recent was for 2008–11) expresses agreement on broad-level priorities and processes for the work of NPIS and its partners over the period (New Plymouth injury Safe n.d.). In addition, annual implementation plans outline

in more detail the actions to be used in the financial year to help deliver the objectives laid down in the Strategic Plan.

Other work by NPiS to support the district's Safe Community designation include participating in national and international networks involving other safe communities (e.g. conferences, workshops).

More recently, in 2009–10, the New Plymouth District Council led the development of a new draft community safety strategy to which NPiS also contributed. Initially called the New Plymouth Safe and Secure Community Strategy 2010-2020 (New Plymouth District Council 2010), it has been described as the 'next step' in the district's 'Safe Community journey'. The strategy aimed to bring together an even greater array of local agencies, initiatives and partnerships than the existing Safe Community concept, and to cover topics not previously addressed such as emergency planning, drugs, and gambling. The draft strategy's vision for New Plymouth District was 'a whole community free from harm' and its five high-level objectives were reducing levels of crime, improving overall feelings of safety, increasing actual levels of safety, embedding a safety culture and growing the knowledge and capacity of people and organisations to respond, and delivering effective and improved coordinated interventions.

Towards the end of 2011, NPiS agreed to lead further community consultation on the draft Safe and Secure Community Strategy, which has been modified and is now called the New Plymouth Community Safety Strategy (New Plymouth District Council / New Plymouth Injury Safe 2011).⁵

Providing locally-relevant information on injury prevention needs, priorities and programmes

In October 2009, NPiS officially launched its new 'one stop shop' Safe Community website: www.safetaranaki.org.nz. More comprehensive than its previous website, the new site aims to be a 'virtual safety resource' enabling people to share information about injury prevention and safety networks and projects across the Taranaki region, but with an emphasis on New Plymouth. The website highlights a wide range of safety topics and provides information about local strategies, groups, projects and resources. Training has been provided to potential users of the website, such as Kidsafe Taranaki and Taranaki Safe Families, to encourage them to manage and update their own sections of the website.

NPiS also prepares and distributes a monthly Community Update newsletter to agencies and people throughout the district and to national networks (e.g. ACC programme managers, Safe Community Coordinators, IPNANZ). The newsletter focuses on local issues, people and stories and promotes local safety events and projects.

Other notable steps taken by NPiS to provide locally-relevant information on injury prevention and safety include:

⁵ Sections of the present needs assessment report (see chapters 11, 12 and 13) include feedback from local people on elements of the draft Community Safety Strategy.

- hosting regular (at least annual) local forums on injury topics
- initiating a monthly column on injury and safety issues in the local free newspaper
- designing, funding and assisting with undertaking the district's five yearly community needs assessment (the latest completed in 2012 and described in this report).

Developing and supporting projects and programmes

Turning now to NPiS's work specifically promoting injury prevention and safety programmes and projects in the district, below are described some of the more significant collaborative programme and projects initiated or supported by the Trust in recent years.⁶

Falls prevention

Falls prevention has been a key focus of NPiS's work since its inception, especially prevention of falls in children and older people. In 2007 the Trust initiated the setting up of the Taranaki Falls Prevention Strategy Group, a regional co-ordinating group made up of representatives from local agencies and groups interested in reducing falls in Taranaki. Subsequently, the Trust obtained \$40,000 from ACC to implement a regional Falls Prevention Strategy, developed by the group and launched in 2008. A major component of the strategy involved developing a series of local falls prevention initiatives focused on older adults including:

- Well Aware
- Wellbeing Days
- falls prevention training workshops for rest home staff
- production of four issues of 'Keeping Up', a falls prevention newsletter
- funding guest speakers to promote exercise to older adults.

Well Aware is a series of community based falls prevention education workshops targeted at people aged 55 and over. Based on the Australian 'Stay on Your Feet' initiative, the six-week programme aims to raise participants' awareness of the risk factors for falls and strategies to reduce them.

Wellbeing Days are one-off community events held periodically through the year to provide opportunities for older people to learn more about health and lifestyle issues related to preventing falls. The implicit goal is to link older people to falls prevention services and provide a stimulus for

⁶ It is important to remember these programme and projects are only a subset of the many dozens of local programmes and projects associated with the broader New Plymouth Safe Community concept.

people to join existing exercise programmes. Participants try out physical exercise activities and have health checks performed by local health professionals. An example of one of these events is the 'Young At Heart' Older Person's Wellbeing Day held at New Plymouth's TSB Stadium in June 2009 to mark World Elder Abuse Awareness Day. The day was organised by NPiS in partnership with Active in Age and the New Plymouth Positive Ageing Trust and featured activities including Tai Chi, indoor bowls, boccia (a game for people with limited motor skills), line dancing, marching and keep fit to music. In addition, participants received free health checks, mirimiri/massage, and suggestions for healthy cooking, as well as advice and information from guest speakers and local health and social service providers attending the day.

Kaumatua Wellbeing Days target Māori older people and are usually held on local marae. Many of the activities provided are based on Māori traditions and practice. For example, the event held at Owae Marae in Waitara in April 2010 included traditional Maori games, raranga (weaving), mirimiri (massage), and waiata (singing), as well as free health checks, Tai Chi, line dancing and aerobics options.

Falls prevention training for rest home staff aims to educate staff about the risk factors for falls in rest homes and enable them to develop action plans to reduce these risks. This includes developing safe and enjoyable structured exercise programmes for rest home clients. The training has been provided as in-house workshops by the NPiS programme manager or the ACC injury prevention consultant. In 2009, workshops were run in a total of 20 Taranaki rest homes, with the workshops continuing to be provided at other venues in 2010 and 2011. NPiS works in collaboration with ACC and Sport Taranaki to fund and provide the workshops.

'Keeping Up' is a quarterly falls prevention newsletter prepared by NPiS and distributed by post and email to its older person's service provider network. The goal of the newsletter is to raise awareness and knowledge of falls prevention issues, share information on good practice and profile local services. Each issue is circulated to more than 200 individual health professionals.

In addition, in recent years NPiS has helped fund or in other ways support the expansion of a range of existing local projects focused on falls prevention or with a falls prevention component. These include:

- Supporting Kidsafe Taranaki's ongoing project to reduce falls in children aged 0–4. The project, developed jointly with ACC and the Taranaki District Health Board's Health Promotion Unit, centres on providing falls prevention group education sessions for caregivers. Sessions are run by trained educators in early childhood centres, kindergartens and various other community settings. The kaupapa Māori component of the project, delivered by Piki te Ora Nursing Services⁷ as part of their Tamariki Ora programme, provides one-to-one falls prevention education to caregivers in their own home.

⁷ Now Tui Ora.

- Providing stair safety gates to low income families in Marfell. This aims to help reduce injuries to children aged 0–4 in the home. Potential recipients are identified by child health nurses and kaiāwhina working with families in Marfell. The stair gates are supplied on loan, with families asked to return them when no longer needed. Recipients are also provided with child home safety information at the time the stair gates are supplied.
- Adding an interactive home safety module to the display areas provided at the Taranaki HSE (Health Safety and Environment) Centre (now rebranded as Be Safe Taranaki or BeST). The home safety module is used for training groups about hazards encountered in the home, including fall hazards. The module also functions as a static display for visitors to the centre.
- Establishing the Taranaki Construction Safety Focus Group and related initiatives aimed at reducing fall-related injuries in the local construction sector. The Safety Focus Group is an informal group of construction industry representatives. Formed in 2008, the group meets on a regular basis to share information and ideas, and plan training programmes, HSE Centre seminars and other initiatives to increase awareness of health and safety issues in the construction industry.
- Initiating the Taranaki Trades Apprentice Safety Challenge competition. This is an annual safety competition organised by the Taranaki Construction Safety Group and held at the Taranaki HSE Centre. The event aims to improve the safety knowledge and skills of trade apprentices. Teams of apprentices from local construction, building and related industries compete to overcome various practical home, road and workplace safety challenges. This includes loading trucks, working on scaffolding, putting out fires and giving first aid.
- Promoting the ACC-funded modified Tai Chi exercise programme for older adults. This is a free exercise course for older people who have experienced a fall. The course is delivered over 16 weeks in community classes. Exercises are modified to suit people who may have strength and balance problems. NPiS promotes the courses through its networks, in local media and at local events including Wellbeing Days (see above). In 2010 a total of eleven 16 week courses were run in nine different venues. Well over a thousand Taranaki residents are estimated to have taken part in the courses in recent years (New Plymouth injury Safe 2010).

Suicide prevention

In 2008 the NPiS Trust was successful in securing \$20,000 from the Ministry of Health to fund a suicide needs assessment research project for the Taranaki region. Channa Perry, the NPiS project manager, led the work on the suicide needs assessment and prepared the final project report, which was widely distributed to agencies throughout the region (New Plymouth Injury Safe 2008). Information for the study was gathered from a range of sources including research literature, available statistical data and key people in the region with a stake in suicide prevention such as mental health service providers and consumers, family / whānau bereaved by suicide, community representatives, Maori representatives and organisations/services in a position to provide suicide prevention and postvention support. The study included a stocktake of existing service provision in Taranaki related to suicide prevention, identifying gaps and needs and highlighting opportunities. As well, a regional action plan was developed, linked to the All Ages New Zealand Suicide Prevention Strategy, outlining steps to be taken to address local needs.

Following on from the suicide needs assessment, in 2009 NPiS took the lead in setting up and initially hosting meetings of a multisectoral co-ordinating group, the Taranaki Suicide Prevention Coordination Group. The group aims to foster greater collaboration and intersectoral working on suicide prevention between local agencies, with an emphasis on training to develop greater suicide prevention awareness and skills in the community.

In recent years, NPiS has also obtained funding to support delivery of the Applied Suicide Intervention Skills Training (ASIST) programme locally. Originally developed in Canada, ASIST courses are two day workshops, run by trained facilitators, where people in gatekeeper roles (e.g. community workers, health workers, clergy, Māori health workers, concerned family members or friends) learn how to better identify someone at risk of suicide and help them access suitable resources and support.

In 2009, following the Taranaki Suicide Prevention Needs Assessment, it was decided that future regional ASiST workshops should be targeted specifically to people working with the two highest suicide risk groups identified in the needs assessment; farmers and Māori rangatahi (youth). Potential workshop participants such as veterinarians and Māori youth workers were identified through NPiS's rural and Māori networks. Funding was secured from sponsors including TSB Community Trust and Peak Health Taranaki (a local primary health organisation)⁸ to ensure workshop fees for participants were kept to a minimum or zero.

Also on the topic of suicide, NPiS has funded and organised various local events and media releases, perhaps most notably the Suicide Prevention Forum developed to support World Suicide Prevention Day on 10 September 2010. The forum was held in the New Plymouth District Council Chamber and included live streaming of presentations from the SPINZ Suicide Prevention forum in

⁸ Peak Health Taranaki no longer exists – the Midlands Health Network is now the primary health organisation for New Plymouth District (and other areas in the central North Island).

Auckland, presentations from local speakers, a live butterfly release, and a lunch and network meeting.

Injury to Māori

In 2007, the NPIS Trust obtained \$30,000 from the Ministry of Health to fund a local, Māori-led participatory action research project on injury prevention. The goal of the project, entitled *Poututangata*, was to look into the injury needs and priorities of Māori in Taranaki using a research approach consistent with Māori protocol and traditions. The approach would put value on 'the knowledge and experience of local whānau and their capacity to come up with solutions to problems affecting them' (New Plymouth Injury Safe 2008a: 8).

A team of Māori community researchers was recruited, guided by a lead researcher and a project steering group of senior Māori figures from across the Taranaki region. NPIS developed job descriptions for the project's research personnel and organised training on participatory action research techniques for the research team. Over two months in 2008 the community researchers gathered information from their communities by attending hui, holding wānanga and interviewing whānau. A structured questionnaire was used to gather information from individuals at these venues with a total of 151 Māori people participating in the research.

The final report of the project, *Poututangata: Māori and Injury Community Action Research*, was completed later in 2008 (New Plymouth injury Safe 2008a). The report concluded there were two injury issues that Māori in the region rated as the most concerning: road safety and violence. Specific road safety issues identified included: speed in residential areas; speed approaching roundabouts; one-lane bridges; narrow country roads; reversing out of driveways; burnouts in urban parks and on rural roads; drunk and drugged drivers on the road; texting and cell phone use while driving; tamariki (children) walking to and from school on roads with speeding traffic; open roads in poor state of repair making them dangerous at 100km/h. Key violence issues identified included concerns at levels of violence, disrespectful behaviour, selfish attitudes and lack of concern for others in the community, which appeared to be increasing. Levels of security and police presence in Taranaki were concluded to be insufficient.

Actions identified as important for advancing Māori injury prevention in Taranaki included increasing the Māori injury prevention workforce, developing a Taranaki Māori injury prevention strategic plan, fostering more collaboration and joint working between existing injury and safety agencies working for and with Māori, and lobbying for an increased profile for Māori and injury prevention and a greater proportion of mainstream resources to be directed at Māori injury prevention.

In September 2008 findings from the project were reported in a community presentation. Following this a *Poututangata Action / Injury Prevention Group* was set up to address the issues raised. However, since then further activities building on the results of the *Poututangata* study have been limited (see chapter 12).

Road safety

In 7 November 2008, NPIS initiated and co-ordinated the running of a 'street party' road safety event, Called 'Schools Reclaiming the Streets Parties', the project aimed to raise drivers' awareness of their speeds on roads close to schools. A party-like gathering of students, teachers and road safety personnel outside a local school draws attention to the presence of the school and the importance of reducing speed. Drivers passing through a checkpoint area close to the school are handed road safety information and asked to reduce speed when driving near the school in future.

Along the same lines, up until 2008 NPIS sponsored and co-ordinated expansion of the Kids Involved in Driving Down Speed (KIDDS) project to a number local primary schools. The project encouraged students aged 9–11 to conduct their own research on road safety issues relevant to their school area. This included collecting and analysing data on vehicle speeds, road conditions and vehicle numbers using speed laser guns, video cameras and other equipment. Students presented their research findings at a local conference and then worked with road safety personnel to implement school-based projects to address identified problems (e.g. installing signs, altering car parking arrangements, new fences, etc).

In May and June 2010, NPIS Trust initiated a local Grim Reaper-styled road intersection safety campaign, based on the nationally advertised NZTA 'Bad Calls Can Be Deadly' Grim Reaper intersection campaign. A competition to find a Grim Reaper 'lookalike' was publicised in local media including the Midweek newspaper. The competition winner agreed to sit beside a replica wheel of misfortune at selected intersections during intervals over a two week period. When stationed near intersections the 'Grim Reaper lookalike' and his wheel of misfortune attracted a great deal of positive public and media attention and helped link the national campaign to local roads and drivers. It was also a stimulus for a lengthier intersection safety project by local police that involved videoing traffic at high risk intersections and issuing tickets for infringements.

The Trust also developed and co-ordinates the running of Ready2Drive, a day-long interactive road and driving safety expo for secondary school students. Schools elect to have the expo set up in the school grounds for the day. The aim of the expo is to promote road safety messages around issues such alcohol, seat belts, road rules and scooter safety. Interactive exhibits include a seatbelt simulator, fatal vision goggles and various computer-based activities. Fire and ambulance service personnel advise students on how to respond at the scene of a road crash and provide vehicle extraction demonstrations. There are also quiz competitions with prize draws at the end of the expo. The event is normally held in school time and is particularly intended for year 10 students (aged 14-15 years) who are about to apply for their learner licence. The event is provided at no cost to schools, and participating road safety personnel give their time for free.

In 2009 a similar project was developed based on the KIDDS model focusing on school bus safety on urban and rural bus routes. Later that year children from seven local primary schools presented their research findings at a school bus project mini-conference sponsored by Roadsafetaranaki.

In 2011 NPIS also supported Rider Training Days run by the Taranaki Motorcycle Safety Group.

NPiS Evaluations

In recent years, NPiS has conducted or commissioned a number of evaluations of injury prevention programmes and projects it has links to. This includes evaluations prepared by the NPiS programme manager or others on projects the Trust has directly initiated, co-ordinated or supported such as KIDDS, Reclaiming The Streets Parties, Ready2Drive expo days, Kaumatua Wellbeing Days, Trades Apprentices Safety Challenge and Child Falls Prevention.⁹ Taken together, the results of these evaluations are a useful guide to how well individual programmes and projects have been received or taken-up by New Plymouth people. In some cases they also examine the degree to which a particular programme or project may have resulted in people changing their beliefs and practices (knowledge / behaviour) relating to aspects of injury risk or safety.

Other recent developments

Looking at changes over the last year or so, it is important to note that currently (February 2012) NPiS does not have a programme manager. The group's first and only programme manager resigned in October 2010 due to uncertainty over ongoing funding for her position. Responsibility for undertaking NPiS's ongoing work since that time has therefore rested largely with core

⁹ Examples of evaluation reports downloadable from the New Plymouth Safe Community website (www.safetaranaki.co.nz) or elsewhere on the internet include:

New Plymouth injury Safe Trust. 2007. *10-P Project Report - KIDDS (Kids Involved in Driving down Speed) Project April 2007 – November 2007*. New Plymouth: New Plymouth injury Safe Trust.

Brown N, Wilson S. 2008. *Taranaki Under Fives Tamariki Falls Prevention Project 2007-2008: Evaluation Report*. Unpublished.

Hope E. 2008. *Taranaki Under Fives Child Falls Prevention Project 2008-2009: Evaluation Report*. Unpublished.

New Plymouth injury Safe Trust. 2008. *10-P Project Report - HSE Centre Gateway Team Challenge September 2008*. New Plymouth: New Plymouth injury Safe Trust.

New Plymouth injury Safe Trust. 2008. *10-P Project Report - Central School Street Party 7th November 2008*. New Plymouth: New Plymouth injury Safe Trust.

New Plymouth injury Safe Trust. 2009. *10-P Project Report - Kaumatua Wellbeing Day 2nd April 2009*. New Plymouth: New Plymouth injury Safe Trust.

New Plymouth injury Safe Trust. 2009. *10-P Project Report - Trades Apprentices Safety Challenge, 13 May 2009, Taranaki HSE Centre*. New Plymouth: New Plymouth injury Safe Trust.

New Plymouth injury Safe Trust. 2009. *10-P Project Report - Taranaki Business House Safety Challenge 11 September 2009, Taranaki HSE Centre*. New Plymouth: New Plymouth injury Safe Trust.

New Plymouth injury Safe Trust. 2009. *10-P Project Report - HSE Centre Gateway Team Challenge September 2009*. New Plymouth: New Plymouth injury Safe Trust.

Summary of results from the evaluation forms completed by students (N=64) participating in the Ready 2 Drive Road Safety Expo, Francis Douglas College, 18 June 2010.

members of the Trust group. This group currently includes representatives from the following nine agencies:

- Tui Ora Ltd, Māori Development Organisation
- Public Health, Taranaki District Health Board (TDHB)
- New Plymouth District Council (NPDC)
- Kidsafe Taranaki Trust
- Accident Compensation Corporation (ACC)
- Department of Labour
- New Plymouth Police
- New Zealand Fire Service
- Midlands Health Network (a regional primary health organisation - PHO)

In addition, the NPiS Trust continues to maintain links with several key 'project coalitions' in the district or wider Taranaki region. These coalitions link into the broader NPiS framework and contribute to the goals of the Safe Community. They include Kidsafe Taranaki, New Plymouth District Alcohol Strategy Group, Roadsafes Taranaki, Taranaki Construction Safety Group, Taranaki Safe Families Trust, Youth Access to Alcohol, Action on Alcohol Taranaki, and the Be Safe Taranaki Centre (BeST).

As indicated in NPiS's application for New Plymouth's re-accreditation as an International Safe Community (ISC), sustainability of funding has become an emerging issue for the Trust. To some extent this is a result of the ongoing economic downturn and associated funding reviews and cutbacks in agencies that traditionally have funded NPiS.

Throughout 2011, the Trust reviewed a range of possible future funding options, with very limited success. However, in December 2011, during a SCFNZ national forum, ACC announced a new funding formula for New Zealand Safe Communities. This formula is based on the size of communities' populations and the stages they are at in the ISC process. Under the formula, NPiS is able to apply for up to \$32,000 for the next two years for injury prevention projects covering ACC priority areas (falls, road and alcohol). A component of the funding can be used for project co-ordination. As a result of this opportunity, NPiS now intends to apply for funding which would enable it to recruit a new programme manager.

2

PEOPLE OF NEW PLYMOUTH DISTRICT

This chapter presents a short socio-demographic profile of the New Plymouth District population. This provides further context for the injury statistics and other material covered in the report. Readers familiar with features of the New Plymouth District population may prefer to skip this chapter and go straight to the first set of injury statistics in the next chapter.

Statistics presented here come mainly from the 2006 Census of Population and Dwellings - the latest available New Zealand census data. With cancellation of the 2011 Census as a result of the Canterbury earthquakes, new census data for New Plymouth is not now likely to be available until the second half of 2013 at the earliest.

Location

New Plymouth District is situated on the western edge of the North Island of New Zealand. It is the northernmost of the three territorial local authorities in the Taranaki region, the others being Stratford and South Taranaki (see figure 1.1 overleaf). Outstanding natural features of the area include the scenic coastline running along the district's north-western boundary and Mount Taranaki and Egmont National Park on the district's southern boundary.

The district's largest urban centre is the city of New Plymouth, located on the coast at the junction of state highways 3 and 45. Smaller urban centres include the towns of Inglewood, Waitara, Bell Block and Oakura.

New Plymouth District includes the following five iwi (Māori tribal) areas (New Plymouth District Council 2012, Taranaki Regional Council 2012):

- Ngāti Tama – in the north-eastern part of the district, including the Mohakatino and Tongaporutu Rivers, Pukearuhe and Parininihi (Whitecliffs)
- Ngāti Maru – in the eastern part of the district, including Tarata, Purangi and the Waitara valley
- Ngāti Mutunga – in the middle, coastal part of the district, including Urenui, Okoki, Mimi and Onaero

- Te Ātiawa – in the south-west of the district around the New Plymouth urban area, Waitara and Inglewood
- Taranaki – to the west of New Plymouth urban area, including Oakura and overlapping the boundary between New Plymouth District and South Taranaki District.

Figure 2.1

Territorial Local Authority Boundaries Taranaki Region, New Zealand



Source: New Plymouth Injury Safe (2010).

Whole population

In 2006 a total of 68,901 people were usually resident in New Plymouth District. This was 66% of the total Taranaki region population of 104,283. The populations of the South Taranaki and Stratford districts were 26,487 and 8,895 respectively.

From 2001–2006 the population of New Plymouth District grew by a total of 2,031 people or 3.5%. This followed a population decrease of 2.2% from 1996–2001 and a 1.4% increase from 2001–2006. This growth rate was slower than the national average (see appendix table 2.1).

Population projections for 2011 based on the 2006 census estimate that the district's current population is about 72,300. The district's population is projected to remain relatively stable over the next 20 years, with between 72,200 and 73,200 residents over this time.

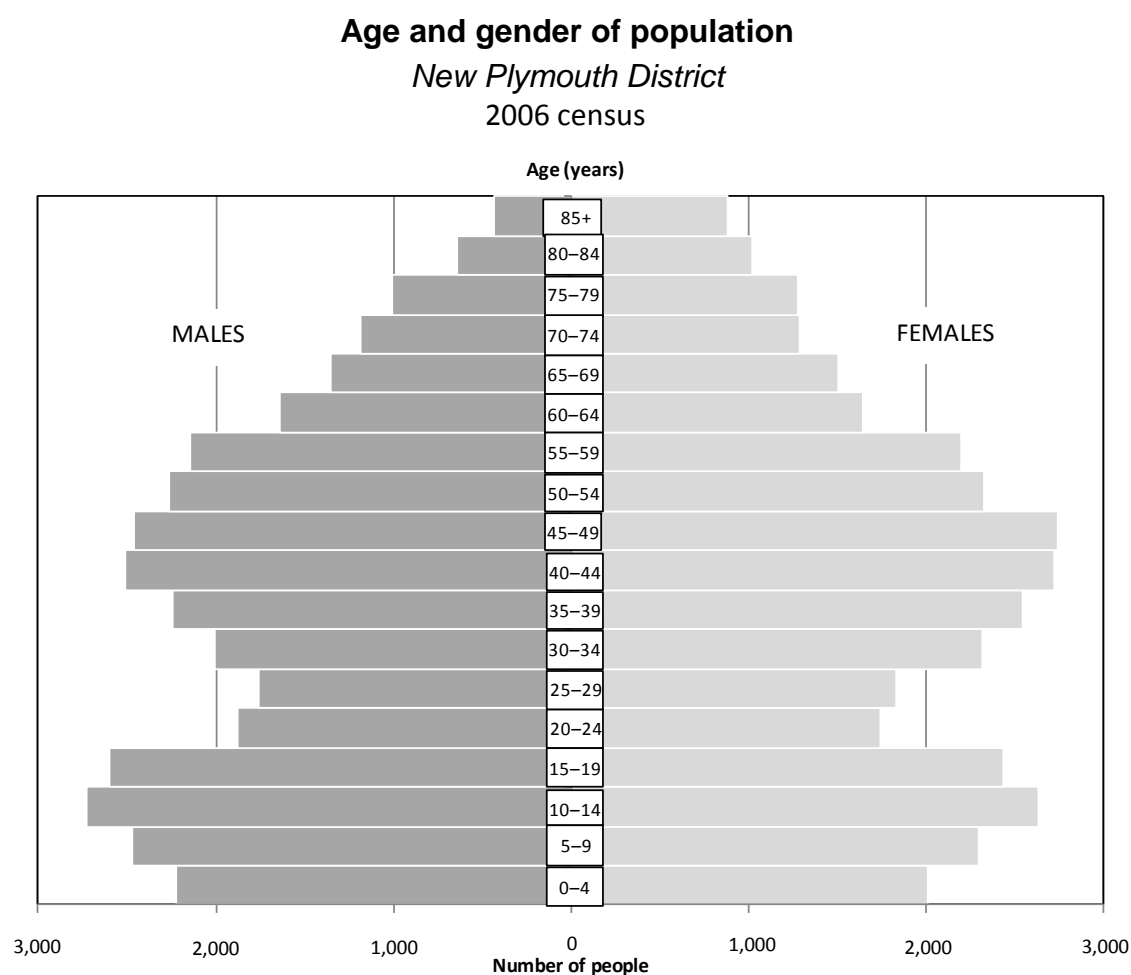
Age and gender

In 2006, the New Plymouth District population consisted of:

- 14,352 children (aged 0–14) (21% of the population)
- 43,953 adults aged 15–64 (64%)
- 9,906 older people aged 65 or more (15%).

See figure 2.2 for a more detailed picture of the age structure of the local population.

Figure 2.2



Source: Statistics New Zealand, 2006 Census of Population and Dwellings

Note: Data in appendix table 2.2

Compared to the total New Zealand population, the New Plymouth District has a higher proportion of older people (15% versus 12%) and a lower proportion of adults in the working age group 15–64 (64% versus 66%).

The proportion of children in the New Plymouth District population is very similar to the New Zealand population (see appendix tables 2.2 and 2.3). The median age for people living in New Plymouth District is 39 compared with 36 for New Zealand as a whole (Statistics New Zealand 2011).

Similar to the whole of New Zealand, in New Plymouth District there are slightly more females (51%) than males (49%).

Māori

In 2006, a total of 9,369 New Plymouth District residents self-identified as Māori.¹⁰ This is 14% of the New Plymouth District population, identical to the proportion of Māori people in the total New Zealand population.

Altogether, 11,079 people (16%) said they were of Māori descent. Of these, 8,085 stated which iwi (tribe or tribes) they belonged to; and 2,424 did not know.¹¹ The most common iwi affiliations were:

- Te Ātiawa (Taranaki) – 2,202
- Ngāpuhi – 1,017
- Taranaki – 813
- Te Ātiawa (region unspecified) – 696
- Ngāti Maniapoto – 681
- Ngāti Ruanui – 612.¹²

As for the whole of New Zealand, the Māori population of New Plymouth District is much younger than the average for all ethnic groups, with a median age of 22 years at the 2006 census (Statistics New Zealand 2011). Over a third (35%) of local Māori were children aged 0–14 years compared with 21% for the whole district population.

¹⁰ This includes people who identified Māori as their only ethnic group and people who identified Māori as one of their ethnic groups.

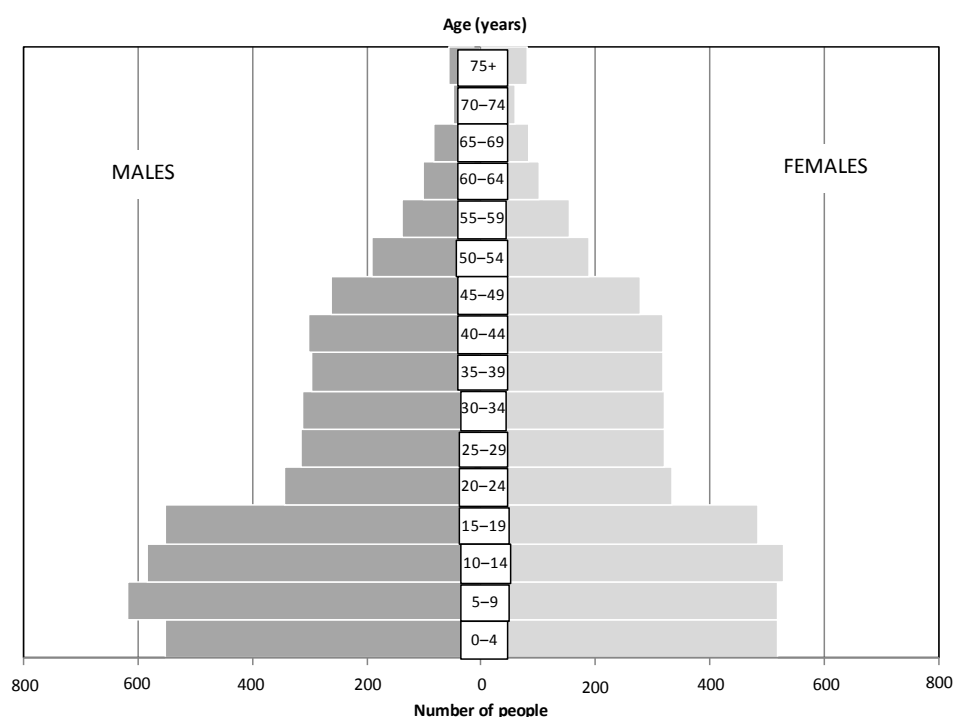
¹¹ 606 were 'not elsewhere included' e.g. if they gave no response.

¹² See appendix table 2.4 for further details.

Only 4% of Māori living in New Plymouth District were aged 65 or older in 2006, compared with 15% of the whole district population (see figure 2.3).

Figure 2.3

Age and gender of Māori population
New Plymouth District
2006 census



Source: Statistics New Zealand, 2006 Census of Population and Dwellings

Note: Data in appendix table 2.2

Other ethnic groups

In 2006, 51,300 New Plymouth District residents (75%) identified themselves as European. This is a higher proportion than in the New Zealand population as a whole (65%). Another 9,417 identified themselves as 'New Zealanders' – 14% compared with 11% nationally.

Much smaller percentages of Pacific and Asian peoples live in New Plymouth District than in New Zealand as a whole. In 2006, 1,749 Asian people lived in the district – 3% compared with 9% nationally. There were 999 Pacific people – 1% compared with 7% nationally (see appendix table 2.5).

Birthplace

In 2006 only 13% of people living in New Plymouth District were not born in New Zealand. This is considerably less than for the country as a whole (22%). The most common overseas birthplaces of people living in New Plymouth District were the UK and Ireland (6% of the population), Asia (2%), and Australia (2%) (see appendix table 2.6).

Urban / rural areas

Almost three-quarters (72%) of New Plymouth District residents live in urban and suburban areas of New Plymouth city. A further 14% live in the city's satellite urban areas of Waitara and Inglewood. Just 15% of the district's residents live in rural areas. Most of these rural areas are considered to be under the 'moderate influence' of an urban area (table 2.1).

Table 2.1

Rural and urban areas New Plymouth District 2006 census

Rural / urban area	Area units	Number	Percent
New Plymouth urban area	Barrett, Bell Block, Bowden, Carrington, Fernleigh, Fitzroy, Frankleigh, Glen Avon, Highlands Park, Kawarua, Lynmouth, Mangaoraka, Marfell, Marsland Hill, Merrilands, Moturoa, Mount Bryan, New Plymouth Central, Oakura, Omata, Paraiti, Spotswood, Struan Pa	49,233	71.5
Satellite urban community	Inglewood, Waitara East, Waitara West	9,384	13.6
Independent urban community	None	0	0.0
Rural area with high urban influence	Parts of Egmont Village, Kaimata, Kaitake, Lepperton, Okato, Okoki-Okau, Urenui	3603	5.2
Rural area with moderate urban influence	Parts of Egmont Village, Kaimata, Kaitake, Lepperton, Okato, Okoki-Okau, Urenui	5,136	7.5
Rural area with low urban influence	Parts of Kaimata, Kaitake, Lepperton, Okoki-Okau	1,344	2.0
Highly rural / remote area	Parts of Kaimata, Kaitake, Okoki-Okau	300	0.4
Area outside rural / urban profile	Oceanic - Taranaki region	18	0.0
Total		68,901	100.0

Source: Statistics New Zealand 2006 area codes, urban-rural concordance and meshblock dataset (all from Statistics New Zealand website www.stats.govt.nz, accessed August 2011)

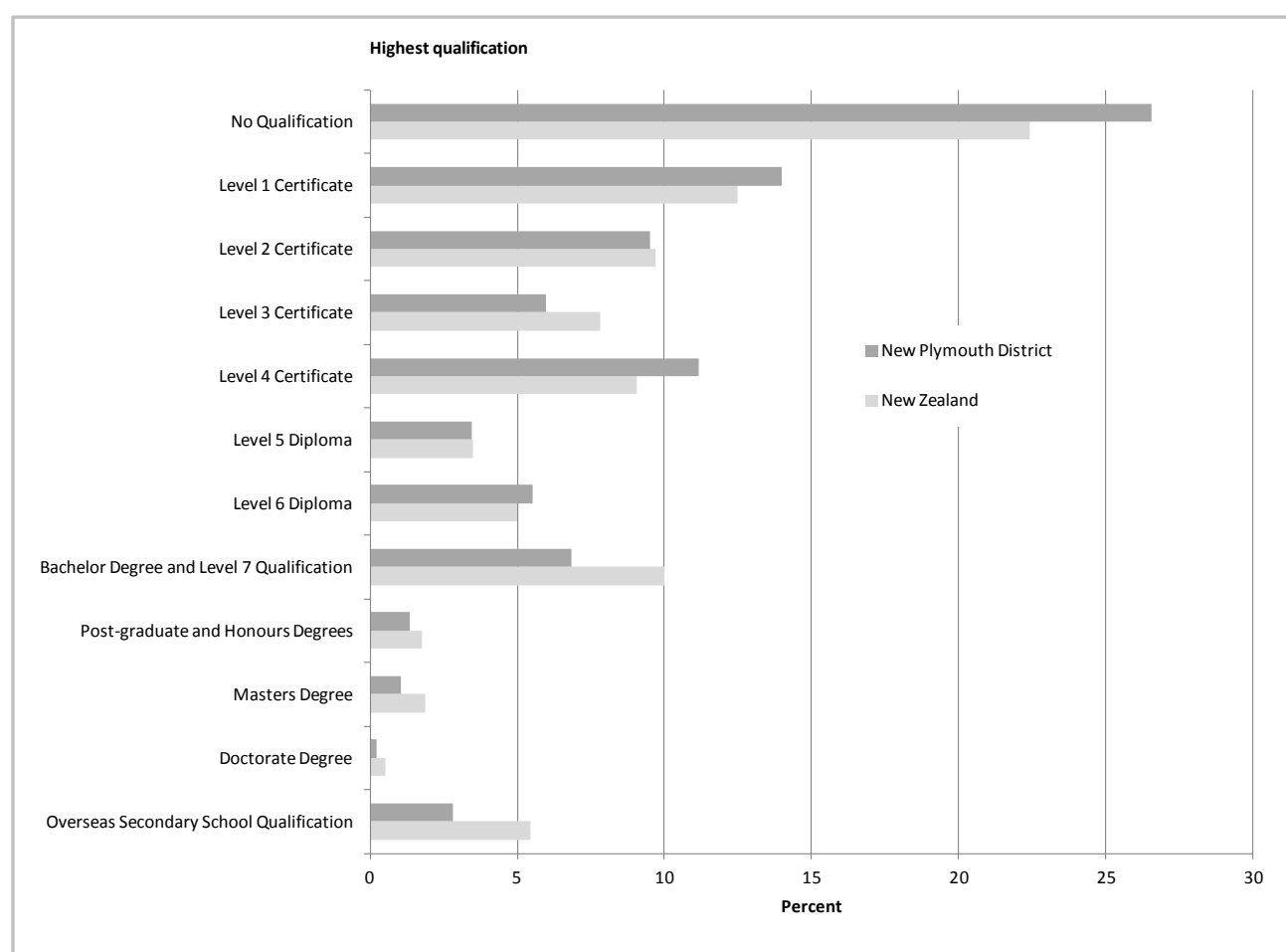
Note: Information is for the usually resident population
Numbers may not sum to the stated totals because they are rounded

Education

New Plymouth District residents tend to have a lower level of formal educational achievement than the national average (figure 2.4). In 2006, 27% of New Plymouth District people aged 15 years and older had no qualifications compared with 22% of all New Zealanders of this age. Nine percent of New Plymouth District people aged 15 years and older had a degree as their highest qualification, compared with 14% of all New Zealanders of the same age.

Figure 2.4

**Highest educational qualification for
people aged 15 years and over**
New Plymouth District and New Zealand
2006 census



Source: Statistics New Zealand, 2006 Census of Population and Dwellings.

Note: Data in appendix table 2.7.

Chart does not show data for 'not elsewhere included' category.

Labour force status

The labour force status of people in New Plymouth District was fairly similar to that of all New Zealand adults. At the 2006 census, of the 54,549 adults aged 15 and over living in New Plymouth District in 2006, 33,918 (62%) were in some form of paid or unpaid employment. This compares with 63% of all New Zealand adults (appendix table 2.8).

A total of 25,665 New Plymouth District people aged 15 years and older (47%) were employed full time and a further 8,253 people (15%) were employed part time (compared with 48% and 14% respectively for New Zealand as a whole). Three percent of local people in this age group were unemployed – the same as New Zealand. New Plymouth District residents were slightly more likely to be ‘not in the labour force’ compared with all New Zealanders (32% compared with 30%) (appendix table 2.8).¹³

Employees / employers

In 2006, just over three-quarters (75%) of the 33,918 New Plymouth District residents who were employed were employees, and 12% were self-employed with no employees. Eight percent were employers and 2% were unpaid family workers. This was similar to the New Zealand pattern (Statistics New Zealand 2011a).

Industries and occupations

In 2006, employed males aged 15 and over living in New Plymouth District most commonly worked in the following industries (appendix table 2.9):

- manufacturing (16% of all employed men)
- construction (13%)
- agriculture / forestry / fishing (9%)
- retail trade (8%)
- professional, scientific and technical services (7%).

¹³ ‘Not in the labour force’ includes retired people, students, invalids, parents looking after children at home, and others who are unable or unavailable to work.

Employed females aged 15 and over living in New Plymouth District most commonly worked in (appendix table 2.9):

- health care and social assistance (18% of all employed women)
- retail trade (13%)
- education and training (12%)
- accommodation and food services (8%)
- professional, scientific and technical services (7%).

The most common occupational groups for New Plymouth District people aged 15 and over in 2006 were:

- professionals (17% of all employed people)
- managers (17%)
- technicians and trades workers (14%).

New Plymouth adults were slightly less likely to be professionals than all New Zealand adults (17% compared with 19%) and were slightly more likely to be technicians and trades workers (14% compared with 12%) (see appendix table 2.10).

Income and income sources

In 2006, New Plymouth District residents had slightly lower than average annual incomes compared with all New Zealanders. The median income for local adults aged 15 and over was \$22,800 compared with the national average of \$24,400. Consistent with this, 45% of New Plymouth district adults earn less than \$20,000 each year compared with 43% of all New Zealand adults (Statistics New Zealand 2012). For more detail see appendix table 2.11.

In 2006, the median income for Māori adults living in New Plymouth District was \$19,100, again slightly less than the national average for Māori of \$20,900. Fifty-two percent of local Māori adults earned less than \$20,000 compared with 48% of all Māori in New Zealand (Statistics New Zealand 2011, see appendix table 2.11).

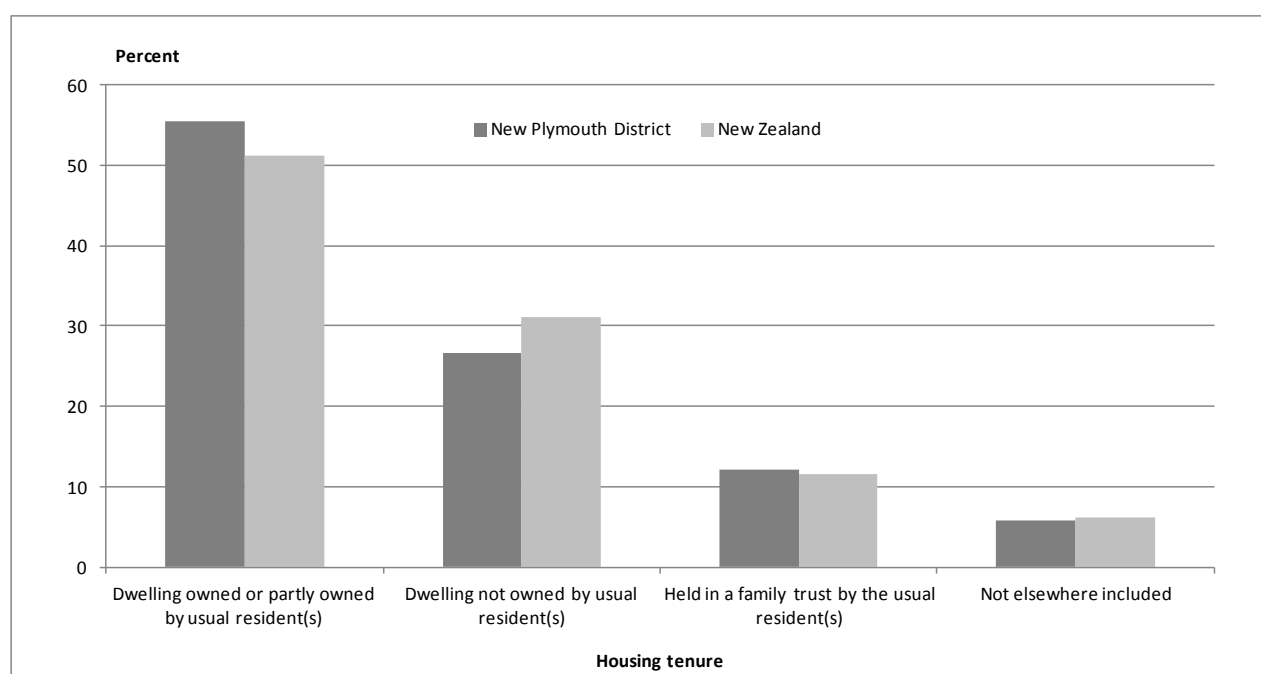
The most frequent types of income sources for New Plymouth District adults were: wages and salaries; investments; and New Zealand Superannuation or Veterans Pension. Compared to New Zealand as a whole, a higher proportion of New Plymouth District adults obtained income from New Zealand Superannuation or Veterans Pension (18% versus 14%). This is consistent with New Plymouth District's comparatively high proportion of people in the 65+ age bracket (appendix table 2.12).

Home ownership

There were 26,508 private dwellings in New Plymouth District in 2006. Of these, 14,742 or 56% were owned or partly owned by the usual residents (either with or without a mortgage). This compares to a national home ownership rate of 51% (figure 2.5). An additional 12% of New Plymouth District dwellings were held in family trusts by the residents, the same figure as for all New Zealand.

Figure 2.5

Household tenure New Plymouth District and New Zealand 2006 census



Source: Statistics New Zealand, 2006 Census of Population and Dwellings

Note: See further data in appendix table 2.13.

In terms of rental accommodation, 27% of residential dwellings in New Plymouth District were not owned by the usual residents. This compares to 31% of dwellings in New Zealand as a whole, indicating that renting is less common in New Plymouth than elsewhere.

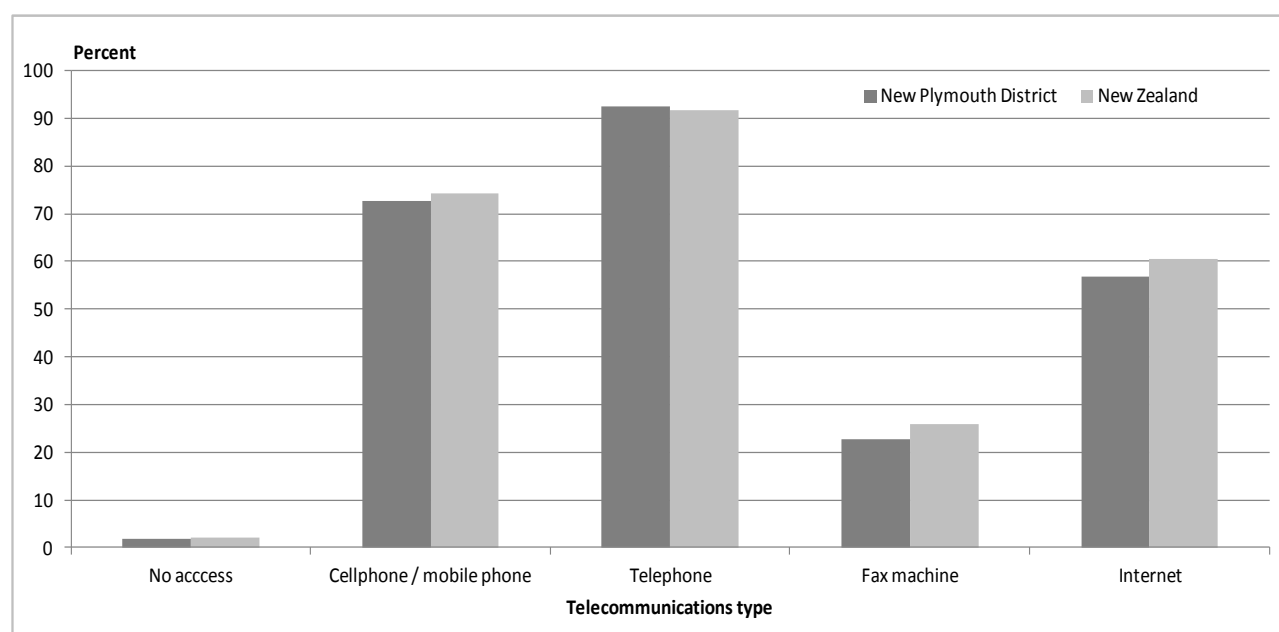
Access to telecommunications and motor vehicles

In 2006, only 2% of New Plymouth District households had no access to telecommunications systems such as a cell phone, telephone, fax or the internet. This was the same as the national average (figure 2.6).

Ninety-three percent of New Plymouth District households had access to a phone (land-line), and 73% had access to a cell-phone, figures similar to New Zealand as a whole. Local households were slightly less likely than all New Zealand households to have internet access (57% vs. 61%) or a fax machine (23% vs. 26%) (appendix table 2.14).

Figure 2.6

Access to telecommunications New Plymouth District and New Zealand 2006 census



Source: Statistics New Zealand, 2006 Census of Population and Dwellings

Note: See further data in appendix table 2.14.

Only eight percent of households in New Plymouth District had no access to a motor vehicle in 2006, the same as all New Zealand households. However, local households were slightly more likely than all New Zealand households to have access to only one vehicle (39% vs. 36%) (appendix table P.15).

Neighbourhood deprivation / Deprivation index (NZDep2006)

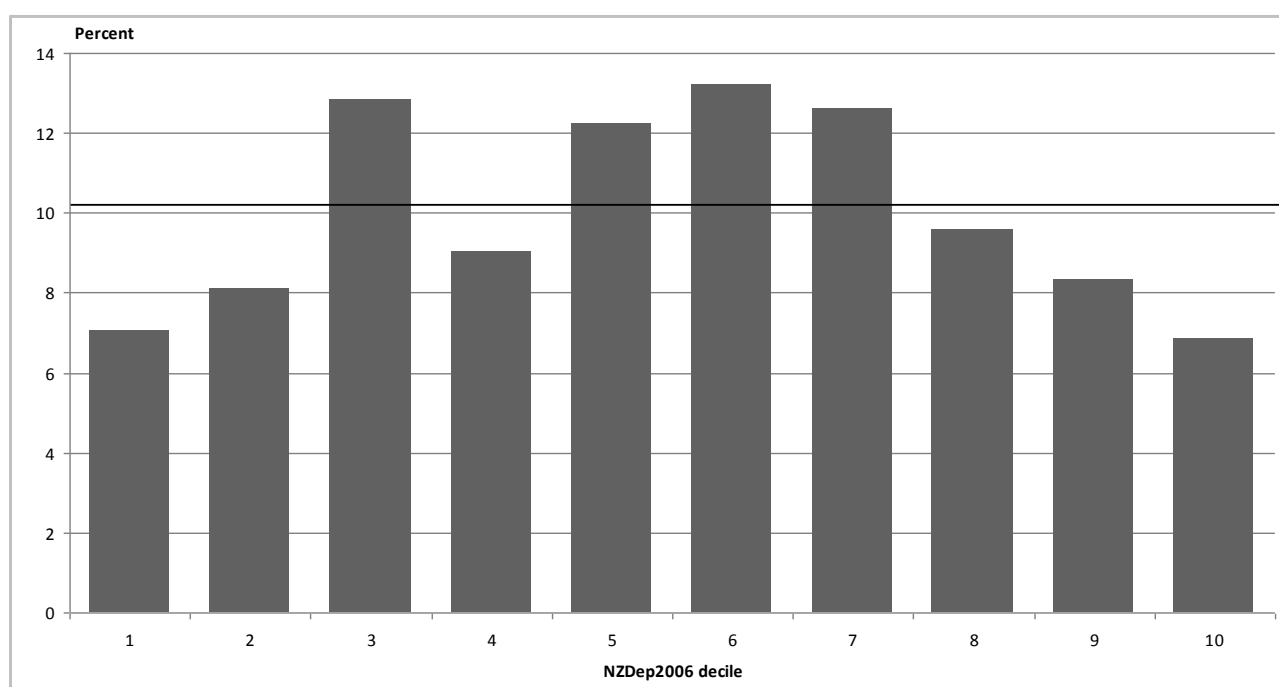
NZDep2006 is a measure or 'index' of the levels of socio-economic deprivation in different geographic areas / neighbourhoods of New Zealand. The index is derived from national census data tracing levels of income, home ownership, sole-parenting, employment, educational qualifications, household living space and access to telephones and cars.

The NZDep2006 index ranges from 1 to 10. A score of 1 indicates that people are living in the least deprived 10% of New Zealand neighbourhoods, while a score of 10 indicates that people are living in the most deprived 10% of New Zealand neighbourhoods (White et al. 2008).

Figure 2.7

New Plymouth District population living in NZDep2006 deciles 1-10

New Plymouth District
2006 census



Source: Statistics New Zealand, 2006 Census of Population and Dwellings

Note: Data in appendix table 2.16
Chart does not show percentages for category 'Not elsewhere included'

Population in each NZDep2006 decile calculated using small meshblocks. Larger area units were used in the previous needs assessment reports (McClellan et al. 2001, 2006) and in the injury statistics calculations (e.g. for hospitalisations). Close to 10% of the New Zealand population lives in each NZDep2006 decile when meshblocks are used in the analysis.

Compared with New Zealand as a whole, lower proportions of people in New Plymouth District live in the least and most deprived neighbourhoods. Higher proportions live in the mid-range neighbourhoods (apart from NZDep2006 decile 4 neighbourhoods).

3

INJURY DEATHS

Death is arguably the most extreme and undesirable outcome of an injury event. Quite apart from the purely emotional impact on family / whānau and the wider community, which in itself can be debilitating and long-lasting, injury deaths have potentially major social and economic impacts in terms of lost productivity and earnings (Wren and Barrell 2010).

The data reported in this chapter has been obtained from medical certificates of cause of death and coroners' reports. The data is compiled by the Ministry of Health as part of its Mortality Collection. Causes of injury death have been categorised according to the International Classification of Diseases (ICD-10) system for coding the external causes of health conditions (E-codes). All deaths caused by injury are included in the analysis except those resulting from medical misadventure.^{14, 15}

Overview of injury deaths

In the five years from 2004 to 2008, a total of 154 New Plymouth District people died as a result of injury.

The lowest annual total of injury deaths in this period was 21 in 2006; the highest was 40 in 2007 (table 3.1 overleaf).

Because the number of injury deaths in a relatively small population like New Plymouth District can vary markedly from year to year, it is better to report *average* totals and rates for the five years 2004–2008 rather than statistics for each individual year. Death totals and rates can therefore be compared more reliably with other districts and New Zealand as a whole. Taking this approach, the average annual number of New Plymouth District injury deaths in 2004–2008 was 31 (appendix table 3.1).

¹⁴ In particular, the following E-code categories have been excluded from the analysis: Y40–Y84 Complications of medical and surgical care, Y88 Sequelae with surgical and medical care as external cause, Y89 Sequelae of other external causes, Y90–Y98 Supplementary factors related to causes of morbidity and mortality classified elsewhere. Deaths from these causes have been excluded because they relate mainly to risk factors in hospitals and other health-care settings, not the wider community.

¹⁵ Note that data for transport accidents for 2007–2008 include the E-codes V00–V99, whereas previously this group of injuries included the codes V01–V99.

Table 3.1**Number of Injury Deaths (All Causes)**

New Plymouth District

2004–2008

YEAR					
2004	2005	2006	2007	2008	Total
37	28	21	40	28	154

Source: Data supplied by Ministry of Health.**Note:** Years are calendar years 1 January to 31 December.

Data for 2008 is provisional.

Overall, the average annual age-standardised injury death rate for New Plymouth District for the period 2004–2008 was 34 per 100,000 population. This was very similar to the New Zealand rate of 35 per 100,000.

Unintentional and intentional injury deaths

Altogether, 65% of New Plymouth District injury deaths were from unintentional injury and 33% were from intentional injury (intentional self-harm and assaults).

However, in the 20–29, 30–39 and 60–69 age groups, over half of all injury deaths were from intentional injury (figure 3.1).

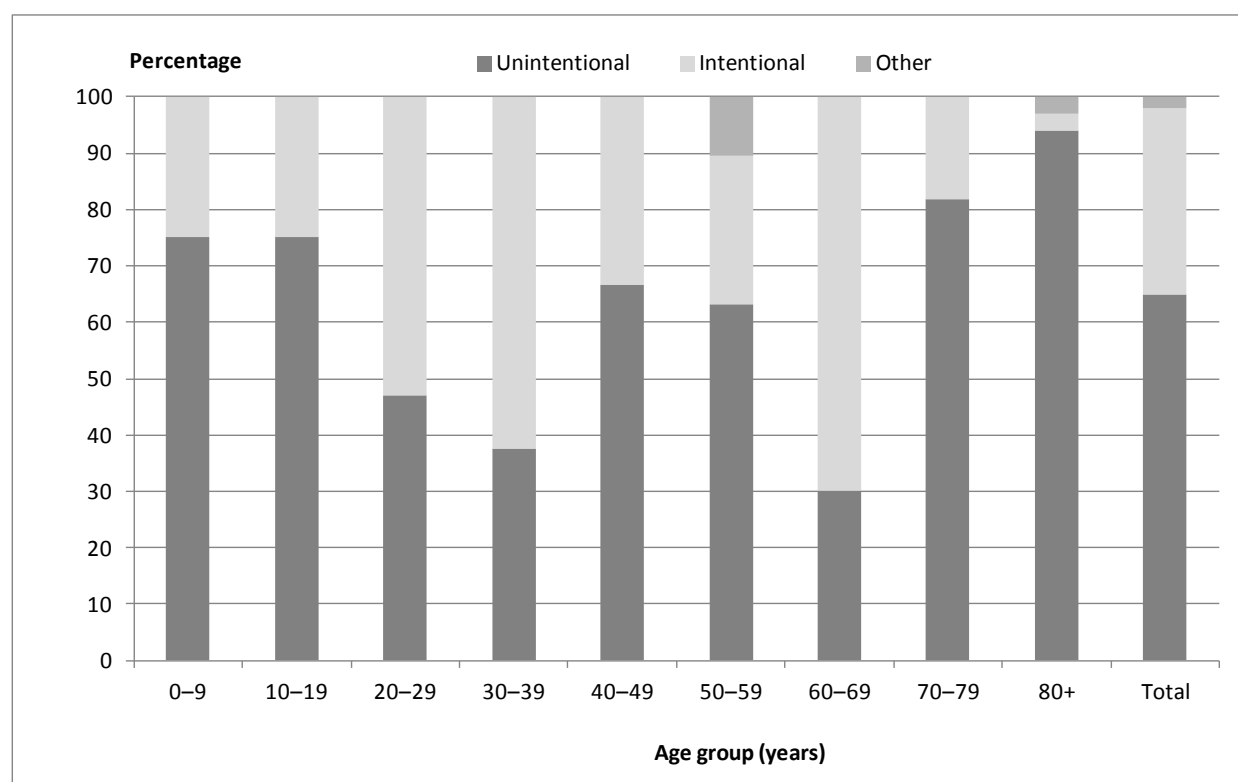
From 2004–2008, for males of all ages, 38% of all injury deaths were from intentional causes, compared with only 23% for females (appendix table 3.2).

During the same period, about one-third of injury deaths were from intentional causes for both Māori (32%) and non-Māori (33%) (appendix table 3.3).

Figure 3.1**Unintentional and Intentional Injury Deaths**

New Plymouth District, by age

Five years 2004–2008 combined



Source: Data supplied by Ministry of Health. Data in appendix table 3.2.

Note: Years are calendar years 1 January to 31 December.
Data for 2008 is provisional.

Specific causes of injury deaths

The three leading causes of injury death in the New Plymouth District population were intentional self-harm (29% of all injury deaths), transport accidents (26%) and falls (23%) (table 3.2 overleaf). Together these three causes accounted for more than three-quarters (78%) of all injury deaths.

The next most common cause was accidental poisoning by and exposure to noxious substances. This accounted for 5% of all New Plymouth District injury deaths in 2004–2008; an average of 1.4 deaths per year.

Table 3.2

Causes of Injury Deaths (ranked)
 New Plymouth District, by ICD-10 E-Code
 Five years 2004–2008 combined

ICD-10 E-code	Description	Average number of injury deaths per year	Total injury deaths 5 years 2004–2008	Percent all injury deaths
X60-X84	Intentional self-harm	8.8	44	28.6
V00-V99	Transport accidents	8.0	40	26.0
W00-W19	Falls	7.2	36	23.4
X40-X49	Accidental poisoning by and exposure to noxious substances	1.4	7	4.5
X85-Y09	Assault	1.4	7	4.5
W65-W74	Accidental drowning and submersion	1.2	6	3.9
W75-W84	Other accidental threats to breathing	0.6	3	1.9
W20-W49	Exposure to inanimate mechanical forces	0.4	2	1.3
W85-W99	Exposure to electric current, radiation, & extreme ambient air pressure	0.4	2	1.3
Y85-Y87	Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	0.4	2	1.3
W50-W64	Exposure to animate mechanical forces	0.2	1	0.6
X30-X39	Exposure to forces of nature	0.2	1	0.6
X50-X57	Over-exertion, travel and privation	0.2	1	0.6
X58-X59	Accidental exposure to other and unspecified factors	0.2	1	0.6
Y10-Y34	Event of undetermined intent	0.2	1	0.6
X00-X09	Exposure to smoke, fire and flames	0.0	0	0.0
X10-X19	Contact with heat and hot substances	0.0	0	0.0
X20-X29	Contact with venomous animals or plants	0.0	0	0.0
Y35-Y36	Legal intervention and operations of war	0.0	0	0.0
	Total – all injury deaths	30.8	154	100.0

Source: Data supplied by Ministry of Health. For a comparison with New Zealand, see appendix table 3.4.

Note: Years are calendar years 1 January to 31 December.
 Data for 2008 is provisional.

The specific E-code causes recorded for the most common causes of injury deaths in 2004–2008 in New Plymouth District – transport accidents, falls and intentional self-harm deaths – are examined below.

Characteristics of fall deaths

Twenty-two of the 36 fall deaths involved falling on the same level from slipping, tripping or stumbling (8) or some other type of fall on the same level (14). Deaths through injury after falling from ladders, scaffolding, stairs or steps were comparatively rare - a total of 4 in the five years (table 3.3).

Table 3.3

Injury Deaths Caused by Falls (ranked)
New Plymouth District, by specific ICD-10 E-Code
Five years 2004–2008 combined

ICD-10 E-code	Description	Total deaths 5 years 2004–2008
W00, W02, W18	Other fall on same level	14
W01	Fall on same level from slipping, tripping or stumbling	8
W04-W08, W14-W17	Other fall from one level to another	5
W19	Unspecified fall	5
W10	Fall on and from stairs and steps	3
W11-W12	Fall on or from ladder or scaffolding	1
W00-W19	Total – all fall injury deaths 2004–2008	36

Source: Data supplied by Ministry of Health.

Note: Years are calendar years 1 January to 31 December.
Data for 2008 is provisional.

Characteristics of transport accident deaths

Of the 40 people fatally injured in transport accidents, 25, almost two-thirds, were car occupants (18) or motorcycle riders (7). It was less common for pedestrians (4) and pedal cyclists (3) to be fatally injured (table 3.4).

Table 3.4

Injury Deaths Caused by Transport Accidents (ranked)

New Plymouth District, by specific ICD-10 E-Code

Five years 2004–2008 combined

ICD-10 E-code	Description	Total deaths 5 years 2004–2008
V42-V44	Car occupant injured in collision with motor vehicle (excl. trains)	13
V22-V24	Motorcycle rider injured in collision with motor vehicle (excl. trains)	6
V40-V41,V45-V49	Car occupant injured other transport accident	5
V02-V04	Pedestrian injured in collision with motor vehicle (excl. trains)	4
V60-V61,V65-V69	Occupant of heavy transport vehicle injured other transport accident	3
V12-V14	Pedal cyclist injured in collision with motor vehicle (excl. trains)	2
V52-V54	Occupant of pickup truck injured in collision with motor vehicle (excl. trains)	2
V80-V89	Other land transport accidents	2
V10-V11,V15-V19	Pedal cyclist injured in other transport accident	1
V20-V21,V25-V29	Motorcycle rider injured in other transport accident	1
V50-V51,V55-V59	Occupant of pickup truck injured other transport accident	1
V00-V99	Total – all transport accident deaths 2004–2008	40

Source: Data supplied by Ministry of Health.

Note: Years are calendar years 1 January to 31 December.
Data for 2008 is provisional.

Characteristics of intentional self-harm deaths

Nearly three-quarters of intentional self-harm deaths were by hanging, strangulation or suffocation, or by firearm discharge (31 out of 44). Self-poisoning using unspecified chemicals or noxious substances including alcohol or gases was another notable cause category. By contrast, it was unusual for self-inflicted deaths to be caused by drugs, medicines or biological substances (excluding alcohol) (table 3.5).

Table 3.5

Injury Deaths Caused by Intentional Self-harm (ranked)

New Plymouth District, by specific ICD-10 E-Code

Five years 2004–2008 combined

ICD-10 E-code	Description	Total deaths 5 years 2004–2008
X70	Intentional self-harm by hanging, strangulation and suffocation	26
X65-X69	Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances, including alcohol and including gases	8
X72-X74	Intentional self-harm by firearm discharge	5
X75-X84	Intentional self-harm by other or unspecified means	3
X60-X64	Intentional self-poisoning by and exposure to drugs, medicaments and biological substances, excluding alcohol	2
X60-X84	Total – all intentional self-harm deaths 2004–2008	44

Source: Data supplied by Ministry of Health.

Note: Years are calendar years 1 January to 31 December.
Data for 2008 is provisional.

Injury deaths in different age groups

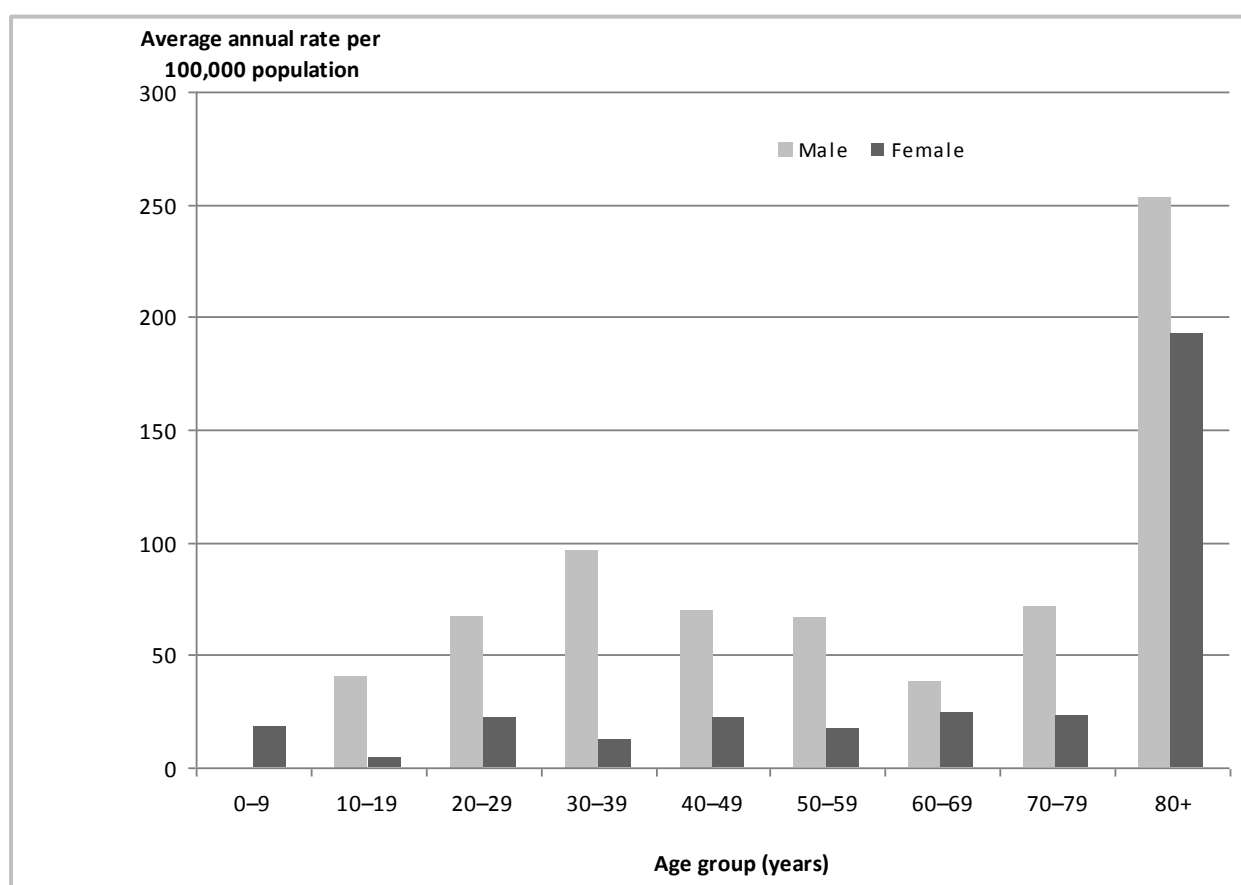
Figure 3.2 shows age-specific average annual injury death rates for New Plymouth District males and females. The rates indicate the probability of males and females in each age group dying from injury. The higher the rate, the greater the probability of males or females in that age group dying from injury.

Injury death rates were by far the highest in the 80+ age group, for males as well as females.

In every age group except 0–9, males had higher injury death rates than females. In the 30–39 age group, males were eight times more likely than females to die from injury.

Figure 3.2

Injury Death Rate New Plymouth District, by age and gender Five years 2004–2008 combined



Source: Data supplied by Ministry of Health. Data in appendix table 3.5.

Note: Years are calendar years 1 January to 31 December.

Data for 2008 is provisional.

Table 3.6 below shows the number of injury deaths from specific causes, for each age group

Table 3.6

Causes of Injury Deaths (ranked)
New Plymouth District, by age and ICD-10 E-Code
Five years 2004–2008 combined

Age 0-9 years		Age 10-19 years		Age 20-29 years	
Injury description	No.	Injury description	No.	Injury description	No.
V00-V99 Transport accidents	1	V00-V99 Transport accidents	6	X60-X84 Intentional self-harm	9
W65-W74 Accidental drowning and submersion	1	W65-W74 Accidental drowning and submersion	1	V00-V99 Transport accidents	4
W75-W84 Other accidental threats to breathing	1	X30-X39 Exposure to forces of nature	1	W00-W19 Falls	2
X85-Y09 Assault	1	X40-X49 Accidental poisoning by and exposure to noxious substances	1	X40-X49 Accidental poisoning by and exposure to noxious substances	2
Total injury deaths 2004–2008	4	X60-X84 Intentional self-harm	2	Total injury deaths 2004–2008	17
		X85-Y09 Assault	1		
		Total injury deaths 2004–2008	12		
Age 30-39 years		Age 40-49 years		Age 50-59 years	
Injury description	No.	Injury description	No.	Injury description	No.
X60-X84 Intentional self-harm	14	V00-V99 Transport accidents	11	V00-V99 Transport accidents	5
V00-V99 Transport accidents	4	X60-X84 Intentional self-harm	7	X60-X84 Intentional self-harm	3
W20-W49 Exposure to inanimate mechanical forces	2	W00-W19 Falls	1	X40-X49 Accidental poisoning by and exposure to noxious substances	2
W00-W19 Falls	1	W65-W74 Accidental drowning and submersion	1	W00-W19 Falls	2
W65-W74 Accidental drowning and submersion	1	W75-W84 Other accidental threats to breathing	1	X85-Y09 Assault	2
W75-W84 Other accidental threats to breathing	1	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	1	W50-W64 Exposure to animate mechanical forces	1
X85-Y09 Assault	1	X40-X49 Accidental poisoning by and exposure to noxious substances	1	W65-W74 Accidental drowning and submersion	1
Total injury deaths 2004–2008	24	X85-Y09 Assault	1	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	1
		Total injury deaths 2004–2008	24	Y10-Y34 Event of undetermined intent	1
				Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	1
				Total injury deaths 2004–2008	19
Age 60-69 years		Age 70-79 years		Age 80+ years	
Injury description	No.	Injury description	No.	Injury description	No.
X60-X84 Intentional self-harm	7	V00-V99 Transport accidents	5	W00-W19 Falls	28
V01-V99 Transport accidents	3	W00-W19 Falls	2	V00-V99 Transport accidents	1
Total injury deaths 2004–2008	10	W65-W74 Accidental drowning and submersion	1	X40-X49 Accidental poisoning by and exposure to noxious substances	1
		X50-X57 Over-exertion, travel and privation	1	X58-X59 Accidental exposure to other and unspecified factors	1
		X60-X84 Intentional self-harm	1	X60-X84 Intentional self-harm	1
		X85-Y09 Assault	1	Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	1
		Total injury deaths 2004–2008	11	Total injury deaths 2004–2008	33

Source: Data supplied by Ministry of Health.

Note: Years are calendar years 1 January to 31 December.

Data for 2008 is provisional.

Also see appendix table 3.6.

The age group with the highest total number of injury deaths was the 80+ group (33 deaths in the 5 years, an average of 6.6 deaths per year). Twenty-eight of these deaths, or 85% of all injury deaths in the 85+ age group, were from falls.

The next highest injury death totals were in the 30–39 and 40–49 age groups. Each of these groups recorded 24 deaths in the 5 years, an average of 4.8 deaths per year. In the 30–39 age group, more than half the injury deaths (14) were the result of intentional self-harm. In the 40–49 age group, transport accidents dominated (11 of the 24 injury deaths) with a further seven deaths the result of intentional self-harm.

Transport accidents also made up a quarter to a half of injury deaths in the 10–19, 20–29, 50–59, 60–69 and 70–79 age groups.

As well as the 30–39 age group, intentional self harm featured strongly in the 20–29 age group (nine of the 17 injury deaths) and the 60–69 age group (seven of the 10 injury deaths)

Injury deaths among males and females

In 2004–2008, males had 2.8 times the average annual age-standardised injury death rates of females (51 per 100,000 population compared with 18 per 100,000) (appendix table 3.5).

Reflecting these rates, of the 154 New Plymouth District people fatally injured in 2004–2008, 106 or 69% were male.

Top of the list for specific causes of injury death for males was intentional self-harm, followed closely by transport accidents (table 3.7). Altogether, 40 out of the 106 male deaths (38%) were from some kind of intentional injury (i.e. intentional self-harm or assault).

The top injury death cause for New Plymouth District females was falls, followed by transport accidents. Intentional self-harm was not quite as prominent for females as for males; nonetheless 11 of the 48 female deaths in the five years (23%) were from intentional injury (self-harm or assault).

Table 3.7

Causes of Injury Deaths (ranked)
 New Plymouth District, by gender and ICD-10 E-Code
 Five years 2004–2008 combined

Male		Female	
Injury description	No.	Injury description	No.
X60-X84 Intentional self-harm	36	W00-W19 Falls	19
V00-V99 Transport accidents	30	V00-V99 Transport accidents	10
W00-W19 Falls	17	X60-X84 Intentional self-harm	8
W65-W74 Accidental drowning and submersion	5	X85-Y09 Assault	3
X40-X49 Accidental poisoning by and exposure to noxious substances	5	X40-X49 Accidental poisoning by and exposure to noxious substances	2
X85-Y09 Assault	4	Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	2
W20-W49 Exposure to inanimate mechanical forces	2	W65-W74 Accidental drowning and submersion	1
W75-W84 Other accidental threats to breathing	2	W75-W84 Other accidental threats to breathing	1
W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	2	X58-X59 Accidental exposure to other and unspecified factors	1
W50-W64 Exposure to animate mechanical forces	1	Y10-Y34 Event of undetermined intent	1
X30-X39 Exposure to forces of nature	1	Total injury deaths 2004–2008	48
X50-X57 Over-exertion, travel and privation	1		
Total injury deaths 2004–2008	106		

Source: Data supplied by Ministry of Health.

Note: Years are calendar years 1 January to 31 December.
 Data for 2008 is provisional.

Injury deaths among Māori and non-Māori

In 2004–2008, Māori had 2.4 times the average annual age-standardised injury death rates of non-Māori (74 per 100,000 population compared with 31 per 100,000) (appendix table 3.7). Of the 31 Māori people fatally injured in 2004–2008, 9 died as a result of transport accidents and 7 by intentional self-harm (table 3.8). Altogether, nearly one-third of Māori injury deaths (10 of 31) were from intentional injury (either self-harm or assault).

Table 3.8

Causes of Injury Deaths (ranked)

New Plymouth District, by ethnic group and ICD-10 E-Code

Five years 2004–2008 combined

Māori		non-Māori	
Injury description	No.	Injury description	No.
V00-V99 Transport accidents	9	X60-X84 Intentional self-harm	37
X60-X84 Intentional self-harm	7	W00-W19 Falls	32
W00-W19 Falls	4	V00-V99 Transport accidents	31
X85-Y09 Assault	3	X40-X49 Accidental poisoning by and exposure to noxious substances	5
W65-W74 Accidental drowning and submersion	2	W65-W74 Accidental drowning and submersion	4
X40-X49 Accidental poisoning by and exposure to noxious substances	2	X85-Y09 Assault	4
W20-W49 Exposure to inanimate mechanical forces	1	W75-W84 Other accidental threats to breathing	2
W75-W84 Other accidental threats to breathing	1	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	2
X30-X39 Exposure to forces of nature	1	W20-W49 Exposure to inanimate mechanical forces	1
Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	1	W50-W64 Exposure to animate mechanical forces	1
Total injury deaths 2004–2008	31	X50-X57 Over-exertion, travel and privation	1
		X58-X59 Accidental exposure to other and unspecified factors	1
		Y10-Y34 Event of undetermined intent	1
		Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	1
		Total injury deaths 2004–2008	123

Source: Data supplied by Ministry of Health.

Note: Years are calendar years 1 January to 31 December.
Data for 2008 is provisional.

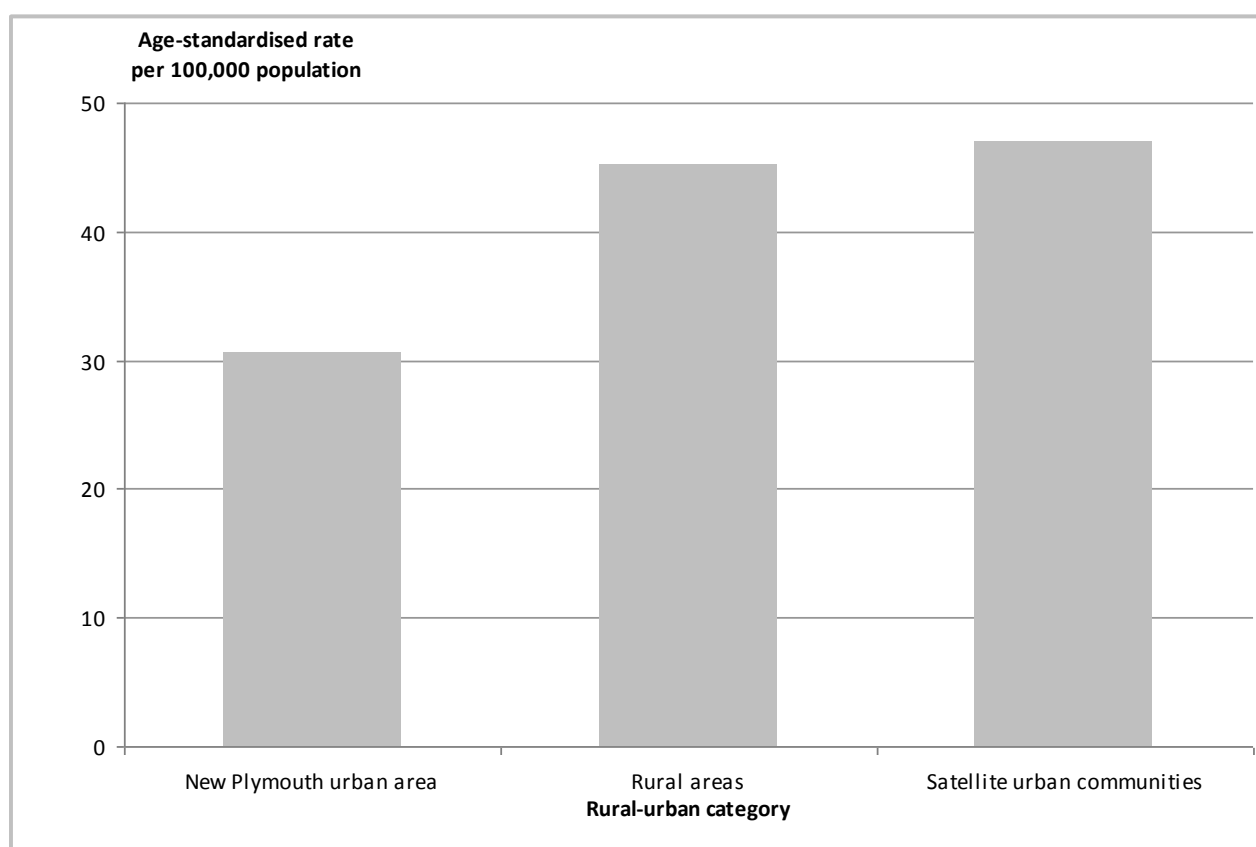
The leading non-Māori injury death cause was intentional self-harm, followed closely by falls and transport accidents. Similar to Māori, 33% of non-Māori injury deaths (41 of 123) were from intentional injury (either self-harm or assault). However, reflecting the older age profile of New Plymouth District's non-Māori population, falls caused 26% of non-Māori injury deaths but just 13% of Māori injury deaths.

Rural-urban areas

New Plymouth District's satellite urban communities (Waitara and Inglewood) had the highest age-standardised injury death rate (figure 3.3). Next highest was in the district's rural areas. New Plymouth urban area's rate was relatively low.

Figure 3.3

Injury Death Rate
New Plymouth District, by rural-urban category
Five years 2004–2008 combined



Source: Data supplied by Ministry of Health. Data in appendix table 3.8.

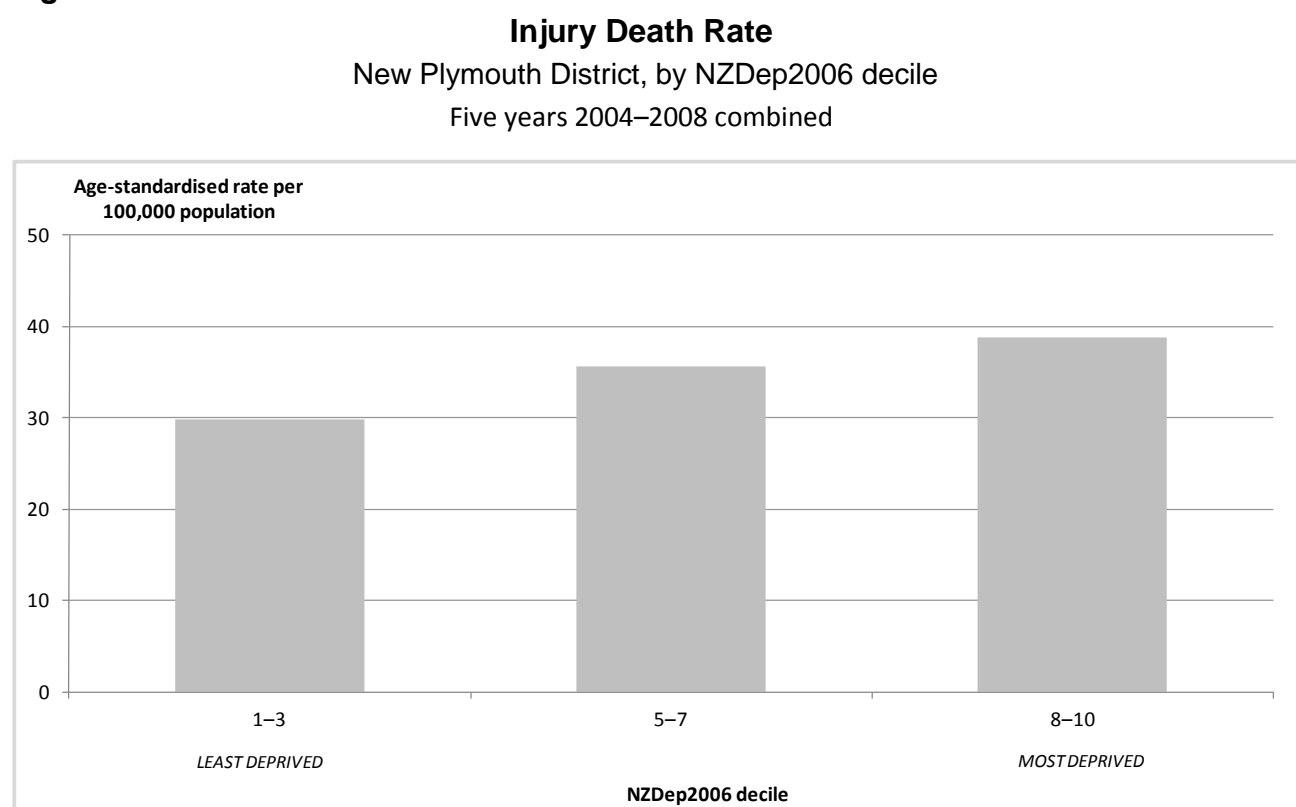
Note: Years are calendar years 1 January to 31 December.
Data for 2008 is provisional.

Neighbourhood deprivation (NZDep2006)

As noted previously in Chapter 2, the New Zealand Deprivation Index 2006 (NZDep2006) is an indicator of levels of relative socioeconomic deprivation in different neighbourhoods of New Zealand. Category 1 on the index refers to the least socioeconomically deprived 10% (decile) of New Zealand's areas. Category 10 refers to the most socioeconomically deprived 10% of New Zealand's areas.

Figure 3.4 shows the injury death rates for New Plymouth District people according to their NZDep2006 category. Those living in categories 8-10, the most deprived populations areas, were more likely to be fatally injured than those living in categories 5-7, or 1-3, the less deprived population areas.

Figure 3.4



Source: Data supplied by Ministry of Health. Data in appendix table 3.9.

Note: Years are calendar years 1 January to 31 December.

Data for 2008 is provisional.

Rates calculated using Statistics NZ 2006 Census data for New Plymouth District.

There is no applicable data for NZDep2006 decile 4.

Trends in injury deaths

Table 3.9 compares New Plymouth District injury death cause data for two periods – the four years from 2000–2003 and the five years from 2004–2008. On the whole the data is similar for both periods although there are some interesting differences.

As mentioned already, falls, transport accidents and intentional self-harm deaths together made up 78% of all injury deaths in New Plymouth District during the five years 2004–2008. This compares to 70% of all injury deaths in the previous four-year period 2000–2003. In particular, falls made up a greater share of all injury causes in 2004–2008 (23%) than in 2000–2003 (19%), as did intentional self-harm (29% versus 24%).

Similarly, the average number of fall injury deaths rose from 5.8 per year in 2000–2003 to 7.2 per year in 2004–2008, while the average number of intentional self-harm deaths rose from 7.0 per year in 2000–2003 to 8.8 per year in 2004–2008. The average number of transport accident injury deaths was unchanged in 2004–2008 compared with 2000–2003 (8.0 per year).

There could be many reasons for these differences (and similarities) including demographic and population changes (e.g. an ageing population could increase the frequency and/or proportion of injury death causes by falls), social, environmental and technical changes that increase or decrease the risk of death from certain injury causes, changes in injury data coding systems (e.g. improved accuracy of coding for certain types of injuries) as well as plain random variation because of the relatively small numbers involved.¹⁶

¹⁶ Because of the relatively small numbers of injury deaths for specific causes, age-specific and age-standardised rates have not been calculated.

Table 3.9

Causes of Injury Deaths (ranked)
 New Plymouth District, by ICD-10 E-Code
 2000–2003 combined, 2004–2008 combined

ICD-10 E-code	Description	Average number of injury deaths per year 2000–2003	Percent all injury deaths 2000–2003	Average number of injury deaths per year 2004–2008	Percent all injury deaths 2004–2008
V00-V99	Transport accidents	8.0	26.9	8.0	26.0
X60-X84	Intentional self-harm	7.0	23.5	8.8	28.6
W00-W19	Falls	5.8	19.3	7.2	23.4
W65-W74	Accidental drowning and submersion	1.5	5.0	1.2	3.9
X40-X49	Accidental poisoning by and exposure to noxious substances	1.3	4.2	1.4	4.5
X85-Y09	Assault	1.3	4.2	1.4	4.5
Y85-Y87	Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	1.3	4.2	0.4	1.3
W75-W84	Other accidental threats to breathing	0.5	1.7	0.6	1.9
W20-W49	Exposure to inanimate mechanical forces	0.5	1.7	0.4	1.3
Y10-Y34	Event of undetermined intent	0.8	2.5	0.2	0.6
X00-X09	Exposure to smoke, fire and flames	0.8	2.5	0.0	0.0
X30-X39	Exposure to forces of nature	0.5	1.7	0.2	0.6
W50-W64	Exposure to animate mechanical forces	0.3	0.8	0.2	0.6
X58-X59	Accidental exposure to other and unspecified factors	0.3	0.8	0.2	0.6
X50-X57	Over-exertion, travel and privation	0.0	0.0	0.2	0.6
Y35-Y36	Legal intervention and operations of war	0.3	0.8	0.0	0.0
X10-X19	Contact with heat and hot substances	0.0	0.0	0.0	0.0
X20-X29	Contact with venomous animals or plants	0.0	0.0	0.0	0.0
W85-W99	Exposure to electric current, radiation, & extreme ambient air pressure	0.0	0.0	0.4	1.3
	Total – all injury deaths	29.8	100.0	30.8	100.0

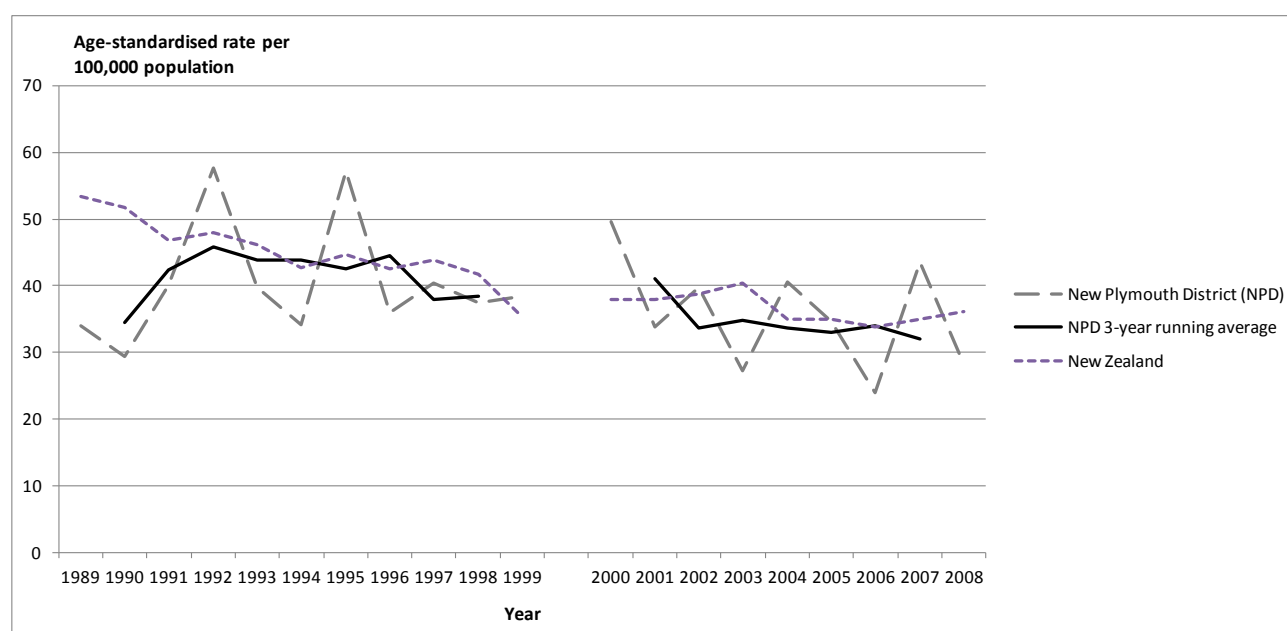
Source: Data supplied by Ministry of Health.

Note: Years are calendar years 1 January to 31 December.
 Data for 2008 is provisional.

Figure 3.5 compares trends in annual injury death rates for New Plymouth District and all of New Zealand. The rates are age-standardised to neutralise the effect of differences in the age-profiles of the New Plymouth and New Zealand populations. The figure also shows three-year running averages for New Plymouth District injury death rates. In relatively small populations like New Plymouth District, annual death rates can vary markedly from year to year. Using three-year running averages helps to smooth out these variations, making it easier to identify trends over time.

Figure 3.5

Age-standardised Annual Injury Death Rate
New Plymouth District and New Zealand
1989–1999, 2000–2008



Source: Data supplied by Ministry of Health. Data in appendix table 3.10.

Note: Years are calendar years 1 January to 31 December.
Data for 2008 is provisional.
In 2000, the ICD classification system changed from ICD-9 to ICD-10.

Comparing New Plymouth District's three-year running averages with the annual rates for all New Zealand shows that both New Plymouth and New Zealand have recorded generally declining injury death rates. In the years 2002 to 2007, which corresponds to the period when the NPIS injury prevention coalition got properly up and running, the district's three-year running average injury death rate was consistently lower than the New Zealand average (apart from 2006 when the local rate was very slightly higher than the national rate).

4

HOSPITALISATIONS FOR INJURY

This chapter presents data on injury hospitalisations in the New Plymouth District population for the five years 2006 to 2010. It also examines longer term trends in the district's injury hospitalisation rates across the 22 years from 1989 to 2010. Where appropriate, comparisons are made with injury hospitalisation data for New Zealand as a whole.

Hospitalisation is defined as a day patient or inpatient admission to a New Zealand public hospital. It excludes hospital emergency department attendances, although a proportion of emergency department patients will subsequently be admitted to hospital as day or inpatients. In general, injuries requiring hospitalisation are more likely to be severe, life-threatening and disabling compared with injuries only requiring treatment in emergency departments, health centres or GP clinics.

A wide range of factors influence the number of injury hospitalisations recorded in any given year. These include variations in the true incidence of injury in the population (itself shaped by a multiplicity of factors), variations in people's treatment-seeking behaviour and access to services, and changes in admission policies or the types of services provided in hospital or non-hospital injury-treatment settings.

Total injury hospitalisations

In the five years 2006–2010, there were 8,149 injury hospitalisations recorded for people in the New Plymouth District. This is an average of 1,630 injury hospitalisations per year.¹⁷

Main causes of injury hospitalisation

Causes of injury hospitalisation are classified using the International Classification of Diseases' (ICD-10) system for coding the external causes of health conditions (E-codes). All hospitalisations caused by injury are included in the analysis except those arising from medical misadventure.

¹⁷ In the previous five years 2001–2005 there were 6,822 injury hospitalisations - an average of 1,364 injury hospitalisations per year.

In the period 2006–2010, 85% of injury hospitalisations were for unintentional causes and 9% were for intentional causes.¹⁸

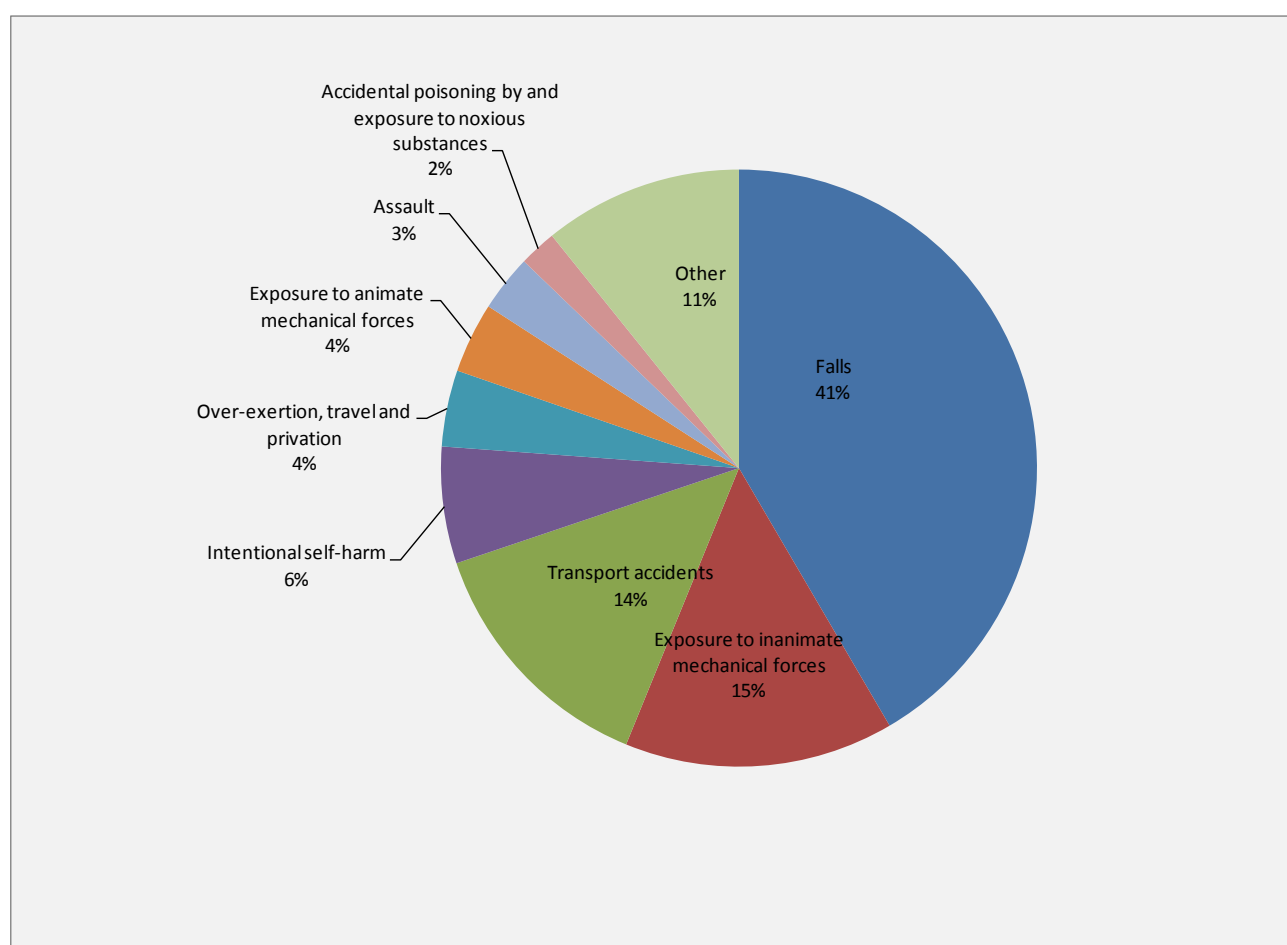
Falls were by far the most common causes of injury hospitalisation. Forty-one percent of all New Plymouth District injury hospitalisations were for falls (figure 4.1).¹⁹

Figure 4.1

Causes of Injury Hospitalisation (ICD 10-E codes)

New Plymouth District

Five years 2006–2010 combined



Source: Data supplied by Ministry of Health. Data in appendix table 4.1. N=8,149.

Note: Years are calendar years 1 January to 31 December.

¹⁸ This was similar to New Zealand's 85% for unintentional injuries and 10% for intentional (appendix table 4.1). In New Plymouth District in 2001–2005, the corresponding figures were 87% and 8% (McClellan et al 2006).

¹⁹ In the district in 2001–2005, 42% of all hospitalisations were for falls (McClellan et al 2006).

The second most common cause of injury hospitalisation was exposure to inanimate mechanical forces (15%). The third was transport accidents (14%).

Intentional self-harm (6%) was the next most common cause of injury hospitalisation, followed by over-exertion, travel and privation (4%), exposure to animate mechanical forces (4%) and assault (3%).

Falls

Table 4.1 indicates the most common specific causes for injury hospitalisations from falls.

Falls on the same level, especially falls on the same level resulting from either slipping, tripping or stumbling, made up the majority of fall hospitalisations (53 %). In addition, a notable proportion of falls hospitalisations were caused by falls from one level to another, such as falls on and from stairs and steps (7%), falls involving playground equipment (5%) and other types of falls from one level to another (12%).

Table 4.1

Specific Causes of Injury Hospitalisation for Falls (ranked)

New Plymouth District, by ICD-10 E-Code

Five years 2006–2010 combined

Injury description	No.	Percent
W01 Fall on same level from slipping, tripping or stumbling	925	27.3
W00, W02, W18 Other fall on same level	877	25.9
W04-W08, W14-W17 Other fall from one level to another	420	12.4
W10 Fall on and from stairs and steps	243	7.2
W09 Fall involving playground equipment	163	4.8
W13 Fall from or out of or through building or structure	111	3.3
W11-W12 Fall on or from ladder or scaffolding	88	2.6
W03 Other fall on same level due to collision with, or pushing by another person	84	2.5
W19 Unspecified fall	476	14.1
Total injury hospitalisations 2006–2010	3,387	100.0

Source: Data supplied by Ministry of Health. Data in appendix table 4.2

Note: Years are calendar years 1 January to 31 December.

Comparing 2006–2010 with 2001–2005, the proportion of falls that were falls on the same level resulting from either slipping, tripping or stumbling were very similar (27% in both periods). The proportion of falls that were ‘other’ falls on the same level was slightly higher in 2006–2010 (26%) compared with 2001–2005 (23%) (McClellan et al 2006).

Inanimate mechanical forces

There was a range of specific causes for injury hospitalisations due to exposure to inanimate (non-living) mechanical forces. The most frequent was contact with sharp glass, knife, sword, dagger or non-powered hand tool (23%) (table 4.2).

Table 4.2

Specific Causes of Hospitalisation for Injury from Inanimate Mechanical Forces (ranked)

New Plymouth District, by ICD-10 E-Code

Five years 2006–2010 combined

Injury description	No.	Percent
W25-W27 Contact with sharp glass, knife, sword, dagger, non-powered hand tool	271	22.8
W22 Striking against or struck by other objects	196	16.5
W24, W41-W43, W45, W49 Exposure to other inanimate mechanical forces	192	16.1
W28-W29,W31 Contact with other and unspecified machinery	182	15.3
W44 Foreign body entering into or through eye or natural orifice	99	8.3
W23 Caught, crushed, jammed or pinched in or between object	92	7.7
W20 Struck by thrown, projected or falling object	85	7.1
W21 Striking against or struck by sports equipment	46	3.9
W30 Contact with agricultural machinery	12	1.0
W39-W40 Discharge of firework, other explosions	8	0.7
W32-W34 Discharge from firearms	4	0.3
W35-W38 Explosion and rupture of pressurised devices	4	0.3
Total injury hospitalisations 2006–2010	1,191	100.0

Source: Data supplied by Ministry of Health. Data in appendix table 4.2

Note: Years are calendar years 1 January to 31 December.
excl = excluding.

Compared with 2001–2005, in 2006–2010 a slightly higher proportion of hospitalisations involved contact with sharp glass, knife, sword, dagger or non-powered hand tool (19% and 23%, respectively). A lower proportion involved a foreign body entering into or through an eye or natural orifice (8% and 12%, respectively) (McClellan et al 2006).

Transport-related accidents

Car occupants (29%), motorcycle riders (27%) and pedal cyclists (17%) featured prominently in the injury hospitalisations caused by transport-related accidents (table 4.3). Altogether, nearly three quarters (74%) of transport-related accident hospitalisations involved these three groups.

Table 4.3

Specific Causes of Injury Hospitalisation for Transport-related Accidents (ranked)

New Plymouth District, by ICD-10 E-Code

Five years 2006–2010 combined

Injury description	No.	Percent
V20-V21,V25-V29 Motorcycle rider injured in other transport accident	239	21.5
V10-V11,V15-V19 Pedal cyclist injured in other transport accident	171	15.4
V40-V41,V45-V49 Car occupant injured other transport accident	168	15.1
V42-V44 Car occupant injured in collision with motor vehicle (excl trains)	157	14.1
V80-V89 Other land transport accidents	129	11.6
V22-V24 Motorcycle rider injured in collision with motor vehicle (excl trains)	65	5.8
V02-V04 Pedestrian injured in collision with motor vehicle (excl trains)	53	4.8
V90-V94 Water transport accidents	33	3.0
V12-V14 Pedal cyclist injured in collision with motor vehicle (excl trains)	22	2.0
V60-V61,V65-V69 Occupant of heavy transport vehicle injured other transport accident	21	1.9
V00,V01,V05-V09 Pedestrian injured in other transport accidents	14	1.3
V50-V51,V55-V59 Occupant of pickup truck injured other transport accident	11	1.0
V70-V71,V75-V79 Bus occupant injured other transport accident	9	0.8
V52-V54 Occupant of pickup truck injured in collision with motor vehicle (excl trains)	8	0.7
V62-V64 Occupant of heavy transport vehicle injured in collision with motor vehicle (excl trains)	4	0.4
V30-V31,V35-V39 Occupant of 3 wheel motor vehicle injured other transport accident	1	0.1
V32-V34 Occupant of 3 wheel motor vehicle injured in collision with motor vehicle (excl trains)	0	0.0
V72-V74 Bus occupant injured in collision with motor vehicle (excl trains)	0	0.0
V95-V97 Air and space transport accidents	0	0.0
V98-V99 Other and unspecified transport accidents	8	0.7
Total injury hospitalisations 2006–2010	1,113	100.0

Source: Data supplied by Ministry of Health. Data in appendix table 4.2

Note: Years are calendar years 1 January to 31 December.

Motorcycle riders made up a greater proportion of transport accident-related injury hospitalisations in 2006–2010 compared to 2001–2005 (27% compared to 19%). In contrast, the proportion of transport accident-related injury hospitalisations involving car occupants fell from 34% in 2001–2005 to 29% in 2006–2010 (McClellan et al 2006).

Animate mechanical forces

Nearly half (46%) of injury hospitalisations caused by exposure to animate (living) mechanical forces involved people being hit, struck, kicked, twisted, bitten, scratched or struck against by these forces. An example is a person being kicked by a horse.

Bites, stings or other kinds of injuries from animals including dogs largely made up the remainder of these types of hospitalisations (table 4.4).

Table 4.4

Specific Causes of Hospitalisation for Injury from Animate Mechanical Forces (ranked)

New Plymouth District, by ICD-10 E-Code

Five years 2006–2010 combined

Injury description	No.	Percent
W50-W52 Hit, struck, kicked, twisted, bitten, scratched, struck against, etc	142	45.7
W53, W55-W59 Bitten, stung, struck, or crushed by another animal	122	39.2
W54 Bitten or struck by dog	39	12.5
W60-W64 Exposure to other animate mechanical forces	8	2.6
Total injury hospitalisations 2006–2010	311	100.0

Source: Data supplied by Ministry of Health. Data in appendix table 4.2

Note: Years are calendar years 1 January to 31 December.

Intentional self-harm

By far the most common form of intentional self-harm leading to hospitalisation was poisoning by and exposure to drugs, medicaments and biological substances (81% – see table 4.5). An example is deliberately overdosing on sleeping pills (table 4.5).

Table 4.5

Specific Causes of Injury Hospitalisation for Intentional Self-harm (ranked)

New Plymouth District, by ICD-10 E-Code

Five years 2006–2010 combined

Injury description	No.	Percent
X60-X64 Intentional self-poisoning by and exposure to drugs, medicaments and biological substances	418	81.2
X70 Intentional self-harm by hanging, strangulation and suffocation	19	3.7
X65-X69 Intentional self-poisoning by and exposure to other and unspecified chemicals	17	3.3
X71 Intentional self-harm by drowning and submersion	0	0.0
X72-X74 Intentional self-harm by firearm discharge	0	0.0
X75-X84 Intentional self-harm by other or unspecified means	61	11.8
Total injury hospitalisations 2006–2010	515	100.0

Source: Data supplied by Ministry of Health. Data in appendix table 4.2

Note: Years are calendar years 1 January to 31 December.

In 2001–2005 a lower proportion of intentional-self harm hospitalisations were for self-poisoning by and exposure to drugs, medicaments and biological substances (76%). A higher proportion were for self-poisoning by and exposure to other and unspecified chemicals (6% in 2001–2005 compared to 3% in 2006–2010) (McClellan et al 2006).

Assault

Over two-thirds (68%) of all assault injury hospitalisations were caused by a bodily force (e.g. hit or struck by a hand or foot) as opposed to a sharp (11%) or blunt (9%) weapon or object (table 4.6).

Table 4.6
Specific Causes of Injury Hospitalisation for Assault (ranked)

New Plymouth District, by ICD-10 E-Code
Five years 2006–2010 combined

Injury description	No.	Percent
Y04 Assault by bodily force	171	68.4
X99 Assault by a sharp object	27	10.8
X85-X92,X96-X98,Y01-Y03,Y08-Y09 Assault by other or unspecified means	26	10.4
Y00 Assault by a blunt object	22	8.8
Y07 Other maltreatment syndromes	3	1.2
Y06 Neglect and abandonment	1	0.4
X93-X95 Assault by firearm discharge	0	0.0
Y05 Sexual assault by bodily force	0	0.0
Total injury hospitalisations 2006–2010	250	100.0

Source: Data supplied by Ministry of Health. Data in appendix table 4.2

Note: Years are calendar years 1 January to 31 December.

The proportion of assault hospitalisations caused by bodily force was higher in 2006–2010 compared to 2001–2005 (68% versus 59%) (McClellan et al 2006). In contrast, the proportion caused by sharp or blunt objects was lower in 2006–2010 compared to 2001–2005 (20% versus 27%).

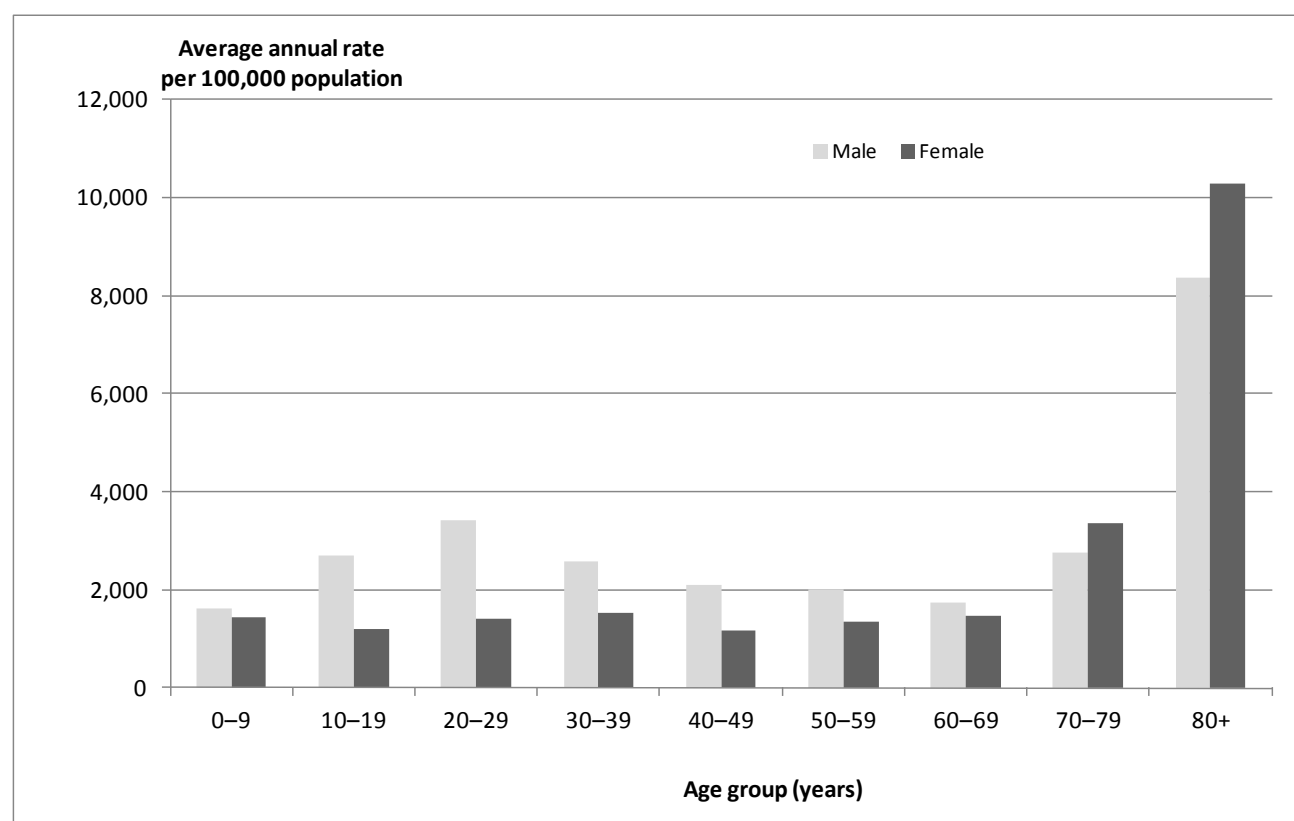
Injury hospitalisation by gender and age

In the five years 2006–2010, there were an average of 896 injury hospitalisations per year for New Plymouth District males and 734 injury hospitalisations per year for New Plymouth District females (appendix table 4.3). Overall, males had a higher age-standardised average annual rate of injury hospitalisation (2,416 per 100,000 population) than females (1,504 per 100,000) (appendix table 4.4).

Age-specific injury hospitalisation rates (per 100,000 population) indicate which New Plymouth age and gender groups were most at risk of being hospitalised for injury (figure 4.2).

Figure 4.2

Rate of Injury Hospitalisation New Plymouth District, by age and gender Five years 2006–2010 combined



Source: Data supplied by Ministry of Health. Data in appendix table 4.4.

Note: Years are calendar years 1 January to 31 December.

Women in the 80+ age group had the greatest risk of injury hospitalisation, with about a one in 10 chance of being hospitalised in any given year (10,291 injury hospitalisations per 100,000). The

next highest risk group was men in the 80+ age group (8,355 injury hospitalisations per 100,000), followed by men in the 20–29 age group (3,408 injury hospitalisations per 100,000).

In all age groups except the 70–79 and 80+ age groups, males had a higher risk of injury hospitalisation than females.

It is useful now to look at which causes of injury hospitalisation were the most common for each age and gender group in New Plymouth District.

Causes of injury hospitalisation – Children aged 0–9

Table 4.7 (overleaf) shows the most common causes of injury hospitalisations for boys and girls aged 0–9 years. Falls were the most common, making up 42% of all injury hospitalisations for males aged 0–9 and nearly half (49%) of all injury hospitalisations for females aged 0–9.

For males aged 0–9, the proportion of injury hospitalisations caused by falls dropped from 49% in 2001–2005 to 42% in 2006–2010. For females aged 0–9, the proportion of injury hospitalisations caused by falls dropped from 52% in 2001–2005 to 49% in 2006–2010 (McClellan et al 2006).

The proportion of injury hospitalisations for males aged 0–9 caused by transport accidents increased from 10% in 2001–2005 to 13% in 2006–2010.

Table 4.7**Causes of Injury Hospitalisation, 0–9 age group (ranked)**

New Plymouth District, by gender and ICD-10 E-Code

Five years 2006–2010 combined

Male			Female		
Injury description	No.	Percent	Injury description	No.	Percent
W00-W19 Falls	167	42.1	W00-W19 Falls	158	49.4
W20-W49 Exposure to inanimate mechanical forces	83	20.9	W20-W49 Exposure to inanimate mechanical forces	50	15.6
V00-V99 Transport accidents	50	12.6	V00-V99 Transport accidents	30	9.4
X40-X49 Accidental poisoning by and exposure to noxious substances	26	6.5	X40-X49 Accidental poisoning by and exposure to noxious substances	20	6.3
W50-W64 Exposure to animate mechanical forces	20	5.0	W50-W64 Exposure to animate mechanical forces	15	4.7
X58-X59 Accidental exposure to other and unspecified factors	17	4.3	W75-W84 Other accidental threats to breathing	11	3.4
X10-X19 Contact with heat and hot substances	16	4.0	X10-X19 Contact with heat and hot substances	10	3.1
W75-W84 Other accidental threats to breathing	4	1.0	X58-X59 Accidental exposure to other and unspecified factors	9	2.8
X50-X57 Over-exertion, travel and privation	4	1.0	X00-X09 Exposure to smoke, fire and flames	5	1.6
X85-Y09 Assault	4	1.0	Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	5	1.6
Y10-Y34 Event of undetermined intent	2	0.5	X50-X57 Over-exertion, travel and privation	4	1.3
Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	2	0.5	X85-Y09 Assault	3	0.9
X00-X09 Exposure to smoke, fire and flames	1	0.3	W65-W74 Accidental drowning and submersion	0	0.0
X20-X29 Contact with venomous animals or plants	1	0.3	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0
W65-W74 Accidental drowning and submersion	0	0.0	X20-X29 Contact with venomous animals or plants	0	0.0
W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0	X30-X39 Exposure to forces of nature	0	0.0
X30-X39 Exposure to forces of nature	0	0.0	X60-X84 Intentional self-harm	0	0.0
X60-X84 Intentional self-harm	0	0.0	Y10-Y34 Event of undetermined intent	0	0.0
Y35-Y36 Legal intervention and operations of war	0	0.0	Y35-Y36 Legal intervention and operations of war	0	0.0
Total injury hospitalisations 2006–2010	397	100.0	Total injury hospitalisations 2006–2010	320	100.0

Source: Data supplied by Ministry of Health. Data in appendix tables 4.3 and 4.4.**Note:** Years are calendar years 1 January to 31 December.

Causes of injury hospitalisation – Young people aged 10–19

For males and females aged 10–19, falls, transport accidents and exposure to inanimate mechanical forces were the most common *unintentional* causes of injury hospitalisations (table 4.8 overleaf). Notably, 21% of injury hospitalisations for females in this age group were a result of intentional self-harm.

For females aged 10–19, the proportion of injury hospitalisations caused by falls dropped from 31% in 2001–2005 to 20% in 2006–2010 (McClellan et al 2006). For males aged 10–19, the proportion of injury hospitalisations caused by falls dropped from 30% to 26%.

For females aged 10–19, the proportion of injury hospitalisations caused by intentional self-harm increased from 13% in 2001–2005 to 21% in 2006–2010 (McClellan et al 2006).

Table 4.8**Causes of Injury Hospitalisation, 10–19 age group (ranked)**

New Plymouth District, by gender and ICD-10 E-Code

Five years 2006–2010 combined

Male			Female		
Injury description	No.	Percent	Injury description	No.	Percent
W00-W19 Falls	186	25.8	V00-V99 Transport accidents	70	23.1
V00-V99 Transport accidents	165	22.9	X60-X84 Intentional self-harm	65	21.5
W20-W49 Exposure to inanimate mechanical forces	138	19.1	W00-W19 Falls	61	20.1
W50-W64 Exposure to animate mechanical forces	50	6.9	W20-W49 Exposure to inanimate mechanical forces	36	11.9
X85-Y09 Assault	45	6.2	W50-W64 Exposure to animate mechanical forces	13	4.3
X60-X84 Intentional self-harm	31	4.3	Y10-Y34 Event of undetermined intent	12	4.0
X58-X59 Accidental exposure to other and unspecified factors	25	3.5	X50-X57 Over-exertion, travel and privation	11	3.6
X50-X57 Over-exertion, travel and privation	24	3.3	X58-X59 Accidental exposure to other and unspecified factors	11	3.6
Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	17	2.4	X85-Y09 Assault	7	2.3
X00-X09 Exposure to smoke, fire and flames	9	1.2	Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	6	2.0
Y10-Y34 Event of undetermined intent	9	1.2	X40-X49 Accidental poisoning by and exposure to noxious substances	5	1.7
X10-X19 Contact with heat and hot substances	6	0.8	X30-X39 Exposure to forces of nature	2	0.7
X40-X49 Accidental poisoning by and exposure to noxious substances	5	0.7	W65-W74 Accidental drowning and submersion	1	0.3
X20-X29 Contact with venomous animals or plants	4	0.6	W75-W84 Other accidental threats to breathing	1	0.3
W75-W84 Other accidental threats to breathing	3	0.4	X10-X19 Contact with heat and hot substances	1	0.3
W65-W74 Accidental drowning and submersion	2	0.3	X20-X29 Contact with venomous animals or plants	1	0.3
W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	1	0.1	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0
X30-X39 Exposure to forces of nature	1	0.1	X00-X09 Exposure to smoke, fire and flames	0	0.0
Y35-Y36 Legal intervention and operations of war	0	0.0	Y35-Y36 Legal intervention and operations of war	0	0.0
Total injury hospitalisations 2006–2010	721	100.0	Total injury hospitalisations 2006–2010	303	100.0

Source: Data supplied by Ministry of Health. Data in tables 4.3 and 4.4.**Note:** Years are calendar years 1 January to 31 December.

Causes of injury hospitalisation – Young adults aged 20–29

The leading cause of injury hospitalisation for males aged 20–29 was exposure to inanimate mechanical forces (24%) (table 4.9 overleaf). However, females aged 20–29 were most likely to be hospitalised for injuries caused by falls (23%), transport accidents (21%) or intentional self-harm (20%).

Intentional self-harm was less frequently a cause for males aged 20–29 (5%). However, assault was the fourth most common cause of injury hospitalisation for this group (11%).

For females aged 20–29, the proportion of injury hospitalisations caused by intentional self-harm dropped from 34% in 2001–2005 to 20% in 2006–2010 (McClellan et al 2006). The proportion of injury hospitalisations caused by traffic accidents dropped from 33% to 21%.

For males aged 20–29, the proportion of injury hospitalisations caused by intentional self-harm dropped from 9% in 2001–2005 to 5% in 2006–2010 (McClellan et al 2006). The proportion caused by assault increased from 8% to 11%.

Table 4.9**Causes of Injury Hospitalisation, 20–29 age group (ranked)**

New Plymouth District, by gender and ICD-10 E-Code

Five years 2006–2010 combined

Male			Female		
Injury description	No.	Percent	Injury description	No.	Percent
W20-W49 Exposure to inanimate mechanical forces	167	24.3	W00-W19 Falls	61	22.8
W00-W19 Falls	119	17.3	V00-V99 Transport accidents	57	21.3
V00-V99 Transport accidents	117	17.1	X60-X84 Intentional self-harm	54	20.1
X85-Y09 Assault	78	11.4	W20-W49 Exposure to inanimate mechanical forces	31	11.6
X60-X84 Intentional self-harm	38	5.5	X85-Y09 Assault	21	7.8
Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	38	5.5	Y10-Y34 Event of undetermined intent	9	3.4
W50-W64 Exposure to animate mechanical forces	35	5.1	W50-W64 Exposure to animate mechanical forces	7	2.6
X58-X59 Accidental exposure to other and unspecified factors	29	4.2	X50-X57 Over-exertion, travel and privation	7	2.6
X50-X57 Over-exertion, travel and privation	23	3.4	X58-X59 Accidental exposure to other and unspecified factors	7	2.6
Y10-Y34 Event of undetermined intent	14	2.0	X40-X49 Accidental poisoning by and exposure to noxious substances	5	1.9
X40-X49 Accidental poisoning by and exposure to noxious substances	11	1.6	Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	5	1.9
X00-X09 Exposure to smoke, fire and flames	10	1.5	X00-X09 Exposure to smoke, fire and flames	3	1.1
X10-X19 Contact with heat and hot substances	4	0.6	W65-W74 Accidental drowning and submersion	1	0.4
X20-X29 Contact with venomous animals or plants	3	0.4	W75-W84 Other accidental threats to breathing	0	0.0
W65-W74 Accidental drowning and submersion	0	0.0	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0
W75-W84 Other accidental threats to breathing	0	0.0	X10-X19 Contact with heat and hot substances	0	0.0
W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0	X20-X29 Contact with venomous animals or plants	0	0.0
X30-X39 Exposure to forces of nature	0	0.0	X30-X39 Exposure to forces of nature	0	0.0
Y35-Y36 Legal intervention and operations of war	0	0.0	Y35-Y36 Legal intervention and operations of war	0	0.0
Total injury hospitalisations 2006–2010	686	100.0	Total injury hospitalisations 2006–2010	268	100.0

Source: Data supplied by Ministry of Health. Data in appendix tables 4.3 and 4.4.**Note:** Years are calendar years 1 January to 31 December.

Causes of injury hospitalisation – Adults aged 30–39

Intentional self-harm (30%) was the leading cause of injury hospitalisation for females aged 30–39. It was also the fifth most common cause of injury hospitalisation for males in this age group (7%) (see table 4.10 overleaf).

Exposure to inanimate mechanical forces was the commonest injury cause for males aged 30–39 (25%), followed by transport accidents (19%) and falls (15%).

For males aged 30–39, the proportion of injury hospitalisations caused by exposure to inanimate mechanical forces dropped from 29% in 2001–2005 to 25% in 2006–2010 (McClellan et al 2006). The proportion caused by traffic accidents dropped from 26% to 19%.

For females in this age group, the proportion of injury hospitalisations caused by intentional self-harm declined from 33% in 2001–2005 to 30% in 2006–2010 (McClellan et al 2006). The proportion caused by falls decreased from 20% to 16% and the proportion caused by transport accidents from 19% to 16%.

Table 4.10**Causes of Injury Hospitalisation, 30–39 age group (ranked)**

New Plymouth District, by gender and ICD-10 E-Code

Five years 2006–2010 combined

Male			Female		
Injury description	No.	Percent	Injury description	No.	Percent
W20-W49 Exposure to inanimate mechanical forces	136	24.9	X60-X84 Intentional self-harm	111	30.4
V00-V99 Transport accidents	106	19.4	W00-W19 Falls	60	16.4
W00-W19 Falls	80	14.7	V00-V99 Transport accidents	58	15.9
Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	54	9.9	W20-W49 Exposure to inanimate mechanical forces	36	9.9
X60-X84 Intentional self-harm	39	7.1	Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	22	6.0
X85-Y09 Assault	29	5.3	X50-X57 Over-exertion, travel and privation	21	5.8
W50-W64 Exposure to animate mechanical forces	27	4.9	W50-W64 Exposure to animate mechanical forces	18	4.9
X50-X57 Over-exertion, travel and privation	22	4.0	X85-Y09 Assault	14	3.8
X00-X09 Exposure to smoke, fire and flames	12	2.2	Y10-Y34 Event of undetermined intent	12	3.3
X58-X59 Accidental exposure to other and unspecified factors	12	2.2	X40-X49 Accidental poisoning by and exposure to noxious substances	7	1.9
X40-X49 Accidental poisoning by and exposure to noxious substances	11	2.0	X58-X59 Accidental exposure to other and unspecified factors	5	1.4
Y10-Y34 Event of undetermined intent	8	1.5	X00-X09 Exposure to smoke, fire and flames	1	0.3
X10-X19 Contact with heat and hot substances	7	1.3	W65-W74 Accidental drowning and submersion	0	0.0
W75-W84 Other accidental threats to breathing	1	0.2	W75-W84 Other accidental threats to breathing	0	0.0
X20-X29 Contact with venomous animals or plants	1	0.2	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0
Y35-Y36 Legal intervention and operations of war	1	0.2	X10-X19 Contact with heat and hot substances	0	0.0
W65-W74 Accidental drowning and submersion	0	0.0	X20-X29 Contact with venomous animals or plants	0	0.0
W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0	X30-X39 Exposure to forces of nature	0	0.0
X30-X39 Exposure to forces of nature	0	0.0	Y35-Y36 Legal intervention and operations of war	0	0.0
Total injury hospitalisations 2006–2010	546	100.0	Total injury hospitalisations 2006–2010	365	100.0

Source: Data supplied by Ministry of Health. Data in appendix tables 4.3 and 4.4.**Note:** Years are calendar years 1 January to 31 December.

Causes of injury hospitalisation – Adults aged 40–49

Intentional self-harm (24%) was the commonest cause of injury hospitalisation for females aged 40–49, followed by falls (21%) and transport accidents (16%) (see table 4.11 overleaf). For males in this age group, the main causes were exposure to inanimate mechanical forces (25%), transport accidents (22%) and falls (18%).

For males aged 40–49, the proportion of injury hospitalisations caused by exposure to inanimate mechanical forces dropped from 29% in 2001–2005 to 25% in 2006–2010 (McClellan et al 2006). The proportion caused by falls dropped from 21% to 17%.

For females aged 40–49, the proportion of injury hospitalisations caused by intentional self-harm reduced from 28% in 2001–2005 to 24% in 2006–2010.

Table 4.11**Causes of Injury Hospitalisation, 40–49 age group (ranked)**

New Plymouth District, by gender and ICD-10 E-Code

Five years 2006–2010 combined

Male			Female		
Injury description	No.	Percent	Injury description	No.	Percent
W20-W49 Exposure to inanimate mechanical forces	135	25.4	X60-X84 Intentional self-harm	75	23.7
V00-V99 Transport accidents	114	21.5	W00-W19 Falls	66	20.8
W00-W19 Falls	93	17.5	V00-V99 Transport accidents	49	15.5
X50-X57 Over-exertion, travel and privation	40	7.5	W20-W49 Exposure to inanimate mechanical forces	35	11.0
Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	37	7.0	X50-X57 Over-exertion, travel and privation	23	7.3
X60-X84 Intentional self-harm	30	5.6	W50-W64 Exposure to animate mechanical forces	19	6.0
X85-Y09 Assault	24	4.5	Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	16	5.0
W50-W64 Exposure to animate mechanical forces	21	4.0	Y10-Y34 Event of undetermined intent	12	3.8
X58-X59 Accidental exposure to other and unspecified factors	13	2.4	X58-X59 Accidental exposure to other and unspecified factors	8	2.5
X40-X49 Accidental poisoning by and exposure to noxious substances	7	1.3	X85-Y09 Assault	5	1.6
X00-X09 Exposure to smoke, fire and flames	4	0.8	X40-X49 Accidental poisoning by and exposure to noxious substances	4	1.3
X10-X19 Contact with heat and hot substances	4	0.8	X00-X09 Exposure to smoke, fire and flames	3	0.9
Y10-Y34 Event of undetermined intent	3	0.6	X10-X19 Contact with heat and hot substances	1	0.3
W65-W74 Accidental drowning and submersion	2	0.4	X20-X29 Contact with venomous animals or plants	1	0.3
W75-W84 Other accidental threats to breathing	2	0.4	W65-W74 Accidental drowning and submersion	0	0.0
W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	1	0.2	W75-W84 Other accidental threats to breathing	0	0.0
X20-X29 Contact with venomous animals or plants	1	0.2	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0
X30-X39 Exposure to forces of nature	0	0.0	X30-X39 Exposure to forces of nature	0	0.0
Y35-Y36 Legal intervention and operations of war	0	0.0	Y35-Y36 Legal intervention and operations of war	0	0.0
Total injury hospitalisations 2006–2010	531	100.0	Total injury hospitalisations 2006–2010	317	100.0

Source: Data supplied by Ministry of Health. Data in appendix tables 4.3 and 4.4.**Note:** Years are calendar years 1 January to 31 December.

Causes of injury hospitalisation – Adults aged 50–59

Falls (40%) were the leading cause of injury hospitalisations among females aged 50–59. For males aged 50–59 it was falls (25%) and exposure to inanimate mechanical forces (24%) (table 4.12).

Compared to younger adult females, for females aged 50–59 intentional self-harm (9%) was less commonly a cause of injury hospitalisation.

For females aged 50–59, the proportion of injury hospitalisations caused by falls was similar in 2001–2005 and 2006–2010 (38 and 40% respectively) (McClellan et al 2006).

For males aged 50–59, the proportion of injury hospitalisations caused by exposure to inanimate mechanical forces reduced from 29% in 2001–2005 to 25% in 2006–2010.

Table 4.12**Causes of Injury Hospitalisation, 50–59 age group (ranked)**

New Plymouth District, by gender and ICD-10 E-Code

Five years 2006–2010 combined

Male			Female		
Injury description	No.	Percent	Injury description	No.	Percent
W00-W19 Falls	116	24.8	W00-W19 Falls	130	39.6
W20-W49 Exposure to inanimate mechanical forces	113	24.1	V00-V99 Transport accidents	43	13.1
V00-V99 Transport accidents	91	19.4	W20-W49 Exposure to inanimate mechanical forces	33	10.1
Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	36	7.7	X60-X84 Intentional self-harm	30	9.1
X50-X57 Over-exertion, travel and privation	30	6.4	Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	23	7.0
W50-W64 Exposure to animate mechanical forces	15	3.2	W50-W64 Exposure to animate mechanical forces	21	6.4
X60-X84 Intentional self-harm	14	3.0	X50-X57 Over-exertion, travel and privation	21	6.4
X58-X59 Accidental exposure to other and unspecified factors	11	2.4	X58-X59 Accidental exposure to other and unspecified factors	8	2.4
X40-X49 Accidental poisoning by and exposure to noxious substances	10	2.1	W75-W84 Other accidental threats to breathing	6	1.8
X85-Y09 Assault	9	1.9	X40-X49 Accidental poisoning by and exposure to noxious substances	6	1.8
Y10-Y34 Event of undetermined intent	9	1.9	Y10-Y34 Event of undetermined intent	6	1.8
X00-X09 Exposure to smoke, fire and flames	4	0.9	X85-Y09 Assault	1	0.3
X20-X29 Contact with venomous animals or plants	3	0.6	W65-W74 Accidental drowning and submersion	0	0.0
W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	2	0.4	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0
X10-X19 Contact with heat and hot substances	2	0.4	X00-X09 Exposure to smoke, fire and flames	0	0.0
W65-W74 Accidental drowning and submersion	1	0.2	X10-X19 Contact with heat and hot substances	0	0.0
W75-W84 Other accidental threats to breathing	1	0.2	X20-X29 Contact with venomous animals or plants	0	0.0
X30-X39 Exposure to forces of nature	1	0.2	X30-X39 Exposure to forces of nature	0	0.0
Y35-Y36 Legal intervention and operations of war	0	0.0	Y35-Y36 Legal intervention and operations of war	0	0.0
Total injury hospitalisations 2006–2010	468	100.0	Total injury hospitalisations 2006–2010	328	100.0

Source: Data supplied by Ministry of Health. Data in appendix tables 4.3 and 4.4.

Note: Years are calendar years 1 January to 31 December.

Causes of injury hospitalisation – Adults aged 60–69

Just over half (51%) of all injury hospitalisations for New Plymouth District women aged 60–69 were caused by falls (see table 4.13). Falls were also the leading cause of injury hospitalisation for New Plymouth District men aged 60–69 (36%). The next most common cause for men was exposure to inanimate mechanical forces (22%).

For females aged 60–69, the proportion of injury hospitalisations caused by falls decreased from 64% in 2001–2005 to 51% in 2006–2010 (McClellan et al 2006).

There was a less dramatic change for males aged 60–69, with the proportion of injury hospitalisations caused by falls only reducing from 38% to 36%.

Table 4.13**Causes of Injury Hospitalisation, 60–69 age group (ranked)**

New Plymouth District, by gender and ICD-10 E-Code

Five years 2006–2010 combined

Male			Female		
Injury description	No.	Percent	Injury description	No.	Percent
W00-W19 Falls	109	36.2	W00-W19 Falls	134	51.1
W20-W49 Exposure to inanimate mechanical forces	67	22.3	V00-V99 Transport accidents	27	10.3
V00-V99 Transport accidents	44	14.6	X50-X57 Over-exertion, travel and privation	24	9.2
Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	18	6.0	W20-W49 Exposure to inanimate mechanical forces	23	8.8
X50-X57 Over-exertion, travel and privation	17	5.6	W50-W64 Exposure to animate mechanical forces	17	6.5
X58-X59 Accidental exposure to other and unspecified factors	10	3.3	X58-X59 Accidental exposure to other and unspecified factors	11	4.2
X60-X84 Intentional self-harm	10	3.3	Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	11	4.2
W50-W64 Exposure to animate mechanical forces	9	3.0	X40-X49 Accidental poisoning by and exposure to noxious substances	5	1.9
X40-X49 Accidental poisoning by and exposure to noxious substances	4	1.3	X60-X84 Intentional self-harm	4	1.5
X85-Y09 Assault	4	1.3	X85-Y09 Assault	3	1.1
X10-X19 Contact with heat and hot substances	3	1.0	W65-W74 Accidental drowning and submersion	1	0.4
W75-W84 Other accidental threats to breathing	2	0.7	X10-X19 Contact with heat and hot substances	1	0.4
Y10-Y34 Event of undetermined intent	2	0.7	Y10-Y34 Event of undetermined intent	1	0.4
W65-W74 Accidental drowning and submersion	1	0.3	W75-W84 Other accidental threats to breathing	0	0.0
X00-X09 Exposure to smoke, fire and flames	1	0.3	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0
W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0	X00-X09 Exposure to smoke, fire and flames	0	0.0
X20-X29 Contact with venomous animals or plants	0	0.0	X20-X29 Contact with venomous animals or plants	0	0.0
X30-X39 Exposure to forces of nature	0	0.0	X30-X39 Exposure to forces of nature	0	0.0
Y35-Y36 Legal intervention and operations of war	0	0.0	Y35-Y36 Legal intervention and operations of war	0	0.0
Total injury hospitalisations 2006–2010	301	100.0	Total injury hospitalisations 2006–2010	262	100.0

Source: Data supplied by Ministry of Health. Data in appendix tables 4.3 and 4.4.

Note: Years are calendar years 1 January to 31 December.

Causes of injury hospitalisation – Adults aged 70–79

Falls were by far the most significant cause of injury hospitalisations for New Plymouth District men and women aged 70–79 (see table 4.14 overleaf). In this age group, 74% of female and 60% of male injury hospitalisations were for falls. The next most common causes - exposure to inanimate mechanical forces and transport accidents – accounted for much lower proportions of injury hospitalisations.

For females aged 70–79, the proportion of injury hospitalisations caused by falls did not change from 2001–2005 to 2006–2010, being 74% in both five-year periods (McClellan et al 2006).

For males aged 70–79, the proportion of injury hospitalisations caused by falls increased slightly over the two periods from 58% to 60%.

Table 4.14**Causes of Injury Hospitalisation, 70–79 age group (ranked)**

New Plymouth District, by gender and ICD-10 E-Code

Five years 2006–2010 combined

Male			Female		
Injury description	No.	Percent	Injury description	No.	Percent
W00-W19 Falls	192	60.4	W00-W19 Falls	330	74.5
W20-W49 Exposure to inanimate mechanical forces	31	9.7	V00-V99 Transport accidents	26	5.9
V00-V99 Transport accidents	22	6.9	W20-W49 Exposure to inanimate mechanical forces	19	4.3
Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	19	6.0	X50-X57 Over-exertion, travel and privation	16	3.6
X58-X59 Accidental exposure to other and unspecified factors	14	4.4	Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	15	3.4
X50-X57 Over-exertion, travel and privation	13	4.1	X40-X49 Accidental poisoning by and exposure to noxious substances	10	2.3
W50-W64 Exposure to animate mechanical forces	8	2.5	X58-X59 Accidental exposure to other and unspecified factors	7	1.6
W75-W84 Other accidental threats to breathing	5	1.6	X60-X84 Intentional self-harm	7	1.6
X10-X19 Contact with heat and hot substances	4	1.3	W50-W64 Exposure to animate mechanical forces	6	1.4
X40-X49 Accidental poisoning by and exposure to noxious substances	4	1.3	W75-W84 Other accidental threats to breathing	3	0.7
X20-X29 Contact with venomous animals or plants	2	0.6	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	1	0.2
X00-X09 Exposure to smoke, fire and flames	1	0.3	X00-X09 Exposure to smoke, fire and flames	1	0.2
X30-X39 Exposure to forces of nature	1	0.3	X10-X19 Contact with heat and hot substances	1	0.2
X60-X84 Intentional self-harm	1	0.3	Y10-Y34 Event of undetermined intent	1	0.2
X85-Y09 Assault	1	0.3	W65-W74 Accidental drowning and submersion	0	0.0
W65-W74 Accidental drowning and submersion	0	0.0	X20-X29 Contact with venomous animals or plants	0	0.0
W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0	X30-X39 Exposure to forces of nature	0	0.0
Y10-Y34 Event of undetermined intent	0	0.0	X85-Y09 Assault	0	0.0
Y35-Y36 Legal intervention and operations of war	0	0.0	Y35-Y36 Legal intervention and operations of war	0	0.0
Total injury hospitalisations 2006–2010	318	100.0	Total injury hospitalisations 2006–2010	443	100.0

Source: Data supplied by Ministry of Health. Data in appendix tables 4.3 and 4.4.

Note: Years are calendar years 1 January to 31 December.

Causes of injury hospitalisation – Adults aged 80+

Falls were far and away the most important cause of injury hospitalisation in the 80+ age group, for both women and men (85% and 83% of all injury hospitalisations respectively – see table 4.15 overleaf).

For females aged 80+, the proportion of injury hospitalisations caused by falls did not change from 2001–2005 to 2006–2010, being 85% in both periods (McClellan et al 2006).

For males aged 80+, the proportion of injury hospitalisations caused by falls dropped slightly, from 85% in 2001–2005 to 83% in 2006–2010.

Table 4.15**Causes of Injury Hospitalisation, 80+ age group (ranked)**

New Plymouth District, by gender and ICD-10 E-Code

Five years 2006–2010 combined

Male			Female		
Injury description	No.	Percent	Injury description	No.	Percent
W00-W19 Falls	424	82.7	W00-W19 Falls	901	84.8
W20-W49 Exposure to inanimate mechanical forces	23	4.5	W20-W49 Exposure to inanimate mechanical forces	35	3.3
V00-V99 Transport accidents	21	4.1	X50-X57 Over-exertion, travel and privation	31	2.9
X40-X49 Accidental poisoning by and exposure to noxious substances	14	2.7	X58-X59 Accidental exposure to other and unspecified factors	24	2.3
X58-X59 Accidental exposure to other and unspecified factors	11	2.1	V00-V99 Transport accidents	23	2.2
W75-W84 Other accidental threats to breathing	6	1.2	X40-X49 Accidental poisoning by and exposure to noxious substances	11	1.0
X50-X57 Over-exertion, travel and privation	6	1.2	Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	10	0.9
X10-X19 Contact with heat and hot substances	2	0.4	W50-W64 Exposure to animate mechanical forces	9	0.8
X60-X84 Intentional self-harm	2	0.4	W75-W84 Other accidental threats to breathing	6	0.6
W50-W64 Exposure to animate mechanical forces	1	0.2	X60-X84 Intentional self-harm	4	0.4
X00-X09 Exposure to smoke, fire and flames	1	0.2	Y10-Y34 Event of undetermined intent	3	0.3
Y10-Y34 Event of undetermined intent	1	0.2	X85-Y09 Assault	2	0.2
Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	1	0.2	X10-X19 Contact with heat and hot substances	1	0.1
W65-W74 Accidental drowning and submersion	0	0.0	X20-X29 Contact with venomous animals or plants	1	0.1
W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0	X30-X39 Exposure to forces of nature	1	0.1
X20-X29 Contact with venomous animals or plants	0	0.0	W65-W74 Accidental drowning and submersion	0	0.0
X30-X39 Exposure to forces of nature	0	0.0	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	0	0.0
X85-Y09 Assault	0	0.0	X00-X09 Exposure to smoke, fire and flames	0	0.0
Y35-Y36 Legal intervention and operations of war	0	0.0	Y35-Y36 Legal intervention and operations of war	0	0.0
Total injury hospitalisations 2006–2010	513	100.0	Total injury hospitalisations 2006–2010	1,062	100.0

Source: Data supplied by Ministry of Health. Data in appendix tables 4.3 and 4.4.**Note:** Years are calendar years 1 January to 31 December.

Injury hospitalisations for Māori and non-Māori

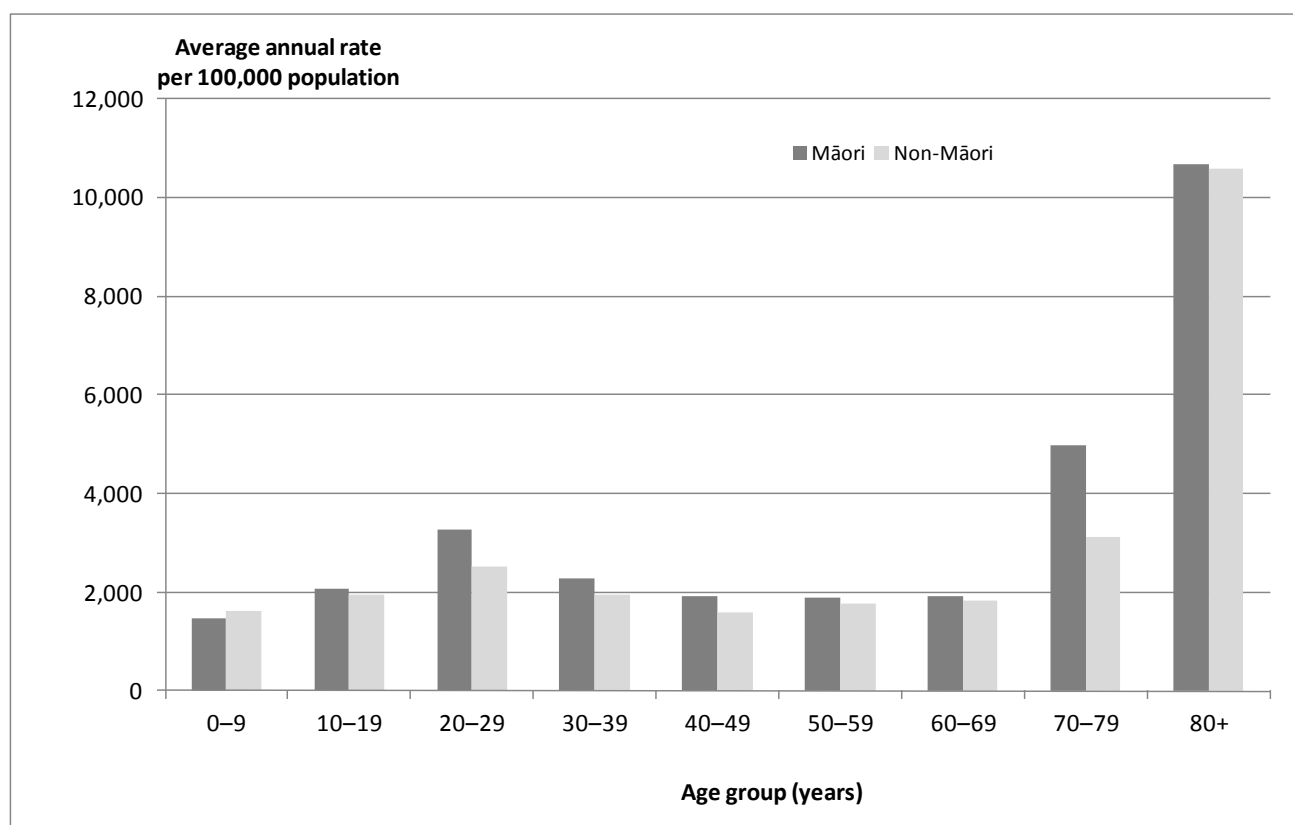
From 2006–2010, 1,034 New Plymouth District Māori and 7,115 New Plymouth District non-Māori were hospitalised for injury. During this period, Māori had slightly higher age-standardised average annual rates of injury hospitalisation (2,287 per 100,000 population) than non-Māori (2,024 per 100,000 population) (appendix table 4.6).

A comparison of age-specific rates of injury hospitalisation for local Māori and non-Māori residents shows which groups were more likely to be hospitalised because of injury.

In all age groups except 0–9, Māori had higher or slightly higher injury hospitalisation rates than non-Māori (figure 4.3). The biggest rate differences between Māori and non-Māori were in the 20–29 and 70–79 age groups.

Figure 4.3

Rate of Injury Hospitalisation
 New Plymouth District, by age and ethnic group
 Five years 2006–2010 combined



Source: Data supplied by Ministry of Health. Data in appendix table 4.6.

Note: Years are calendar years 1 January to 31 December.
 Rates calculated using Statistics NZ 2006 Census data for New Plymouth District.

For both Māori and non-Māori, falls, exposure to inanimate mechanical forces and transport accidents were the three commonest causes of injury hospitalisations (table 4.16). Falls made up a bigger share of non-Māori injury hospitalisations at least in part because this population group is comparatively older than the Māori group (see previous demographic section).

Table 4.16**Causes of Injury Hospitalisation, Māori and Non-Māori (ranked)**

New Plymouth District, by ICD-10 E-Code

Five years 2006–2010 combined

Māori			Non-Māori		
Injury description	No.	Percent	Injury description	No.	Percent
W00-W19 Falls	316	30.6	W00-W19 Falls	3,071	43.2
W20-W49 Exposure to inanimate mechanical forces	172	16.6	W20-W49 Exposure to inanimate mechanical forces	1019	14.3
V00-V99 Transport accidents	121	11.7	V00-V99 Transport accidents	992	13.9
X85-Y09 Assault	84	8.1	X60-X84 Intentional self-harm	432	6.1
X60-X84 Intentional self-harm	83	8.0	X50-X57 Over-exertion, travel and privation	304	4.3
W50-W64 Exposure to animate mechanical forces	61	5.9	Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	290	4.1
Y85-Y87 Sequelae of transport, other accidents, intentional self-harm, assault and events of undetermined intent	45	4.4	W50-W64 Exposure to animate mechanical forces	250	3.5
X40-X49 Accidental poisoning by and exposure to noxious substances	37	3.6	X58-X59 Accidental exposure to other and unspecified factors	200	2.8
X50-X57 Over-exertion, travel and privation	33	3.2	X85-Y09 Assault	166	2.3
X58-X59 Accidental exposure to other and unspecified factors	32	3.1	X40-X49 Accidental poisoning by and exposure to noxious substances	128	1.8
Y10-Y34 Event of undetermined intent	19	1.8	Y10-Y34 Event of undetermined intent	85	1.2
X10-X19 Contact with heat and hot substances	13	1.3	X00-X09 Exposure to smoke, fire and flames	52	0.7
W75-W84 Other accidental threats to breathing	7	0.7	X10-X19 Contact with heat and hot substances	50	0.7
X00-X09 Exposure to smoke, fire and flames	4	0.4	W75-W84 Other accidental threats to breathing	44	0.6
W65-W74 Accidental drowning and submersion	2	0.2	X20-X29 Contact with venomous animals or plants	16	0.2
X20-X29 Contact with venomous animals or plants	2	0.2	W65-W74 Accidental drowning and submersion	7	0.1
X30-X39 Exposure to forces of nature	2	0.2	W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	4	0.1
W85-W99 Exposure to electric current, radiation, & extreme ambient air pressure	1	0.1	X30-X39 Exposure to forces of nature	4	0.1
Y35-Y36 Legal intervention and operations of war	0	0.0	Y35-Y36 Legal intervention and operations of war	1	0.0
Total injury hospitalisations 2006–2010	1,034	100.0	Total injury hospitalisations 2006–2010	7,115	100.0

Source: Data supplied by Ministry of Health. Data in appendix tables 4.5 and 4.6.

Note: Years are calendar years 1 January to 31 December.

For New Plymouth District Māori, the proportion of injury hospitalisations caused by falls was slightly higher in 2006–2010 compared to 2001–2005 (31% versus 28%) (McClellan et al 2006).

For non-Māori, the proportion of injury hospitalisations caused by falls in 2006–2010 and 2001–2005 was the same – 43%.

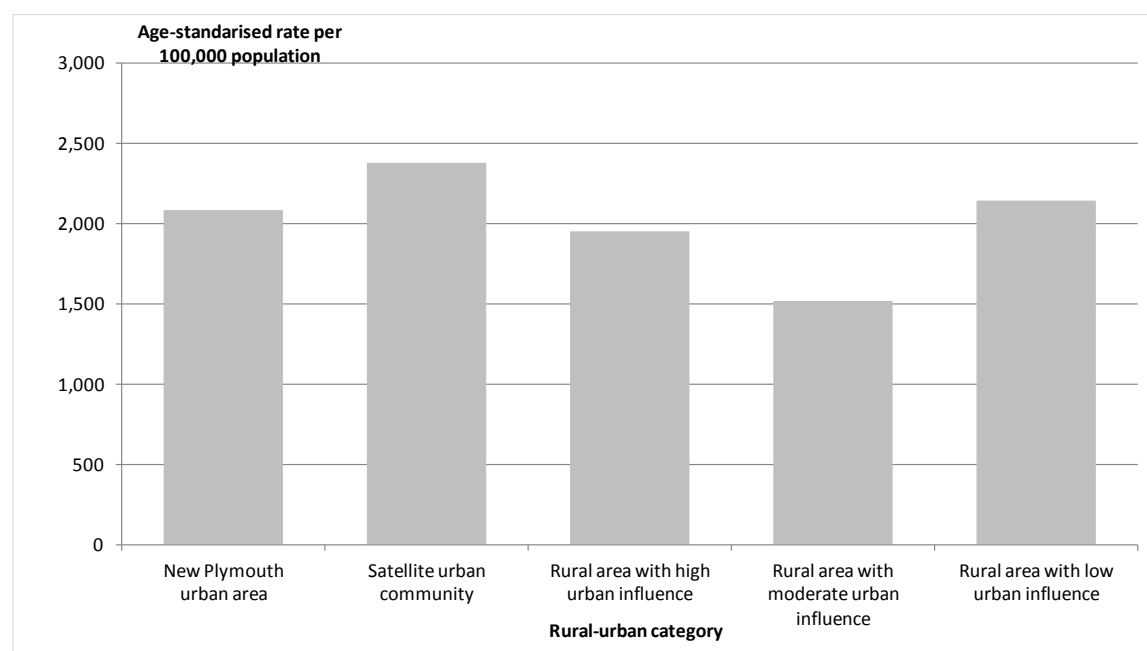
Similarly, over the two time periods there was very little change in the proportion of injury hospitalisations caused by transport accidents, either for Māori or non-Māori.

Rural and urban areas

In 2006–2010, people living in satellite urban communities of New Plymouth District had the highest age-standardised injury hospitalisation rate (figure 4.4). Next were people living in rural areas with a low urban influence. People living in rural areas with a moderate urban influence had the lowest rate.

Figure 4.4

Injury Hospitalisation New Plymouth District, by rural-urban category Five years 2006–2010 combined



Source: Data supplied by Ministry of Health. Data in appendix table 4.7.

Note: Years are calendar years 1 January to 31 December.

Rates calculated using Statistics NZ 2006 Census data for New Plymouth District.

Age-standardised rates (ASRs) calculated using Segi world population.

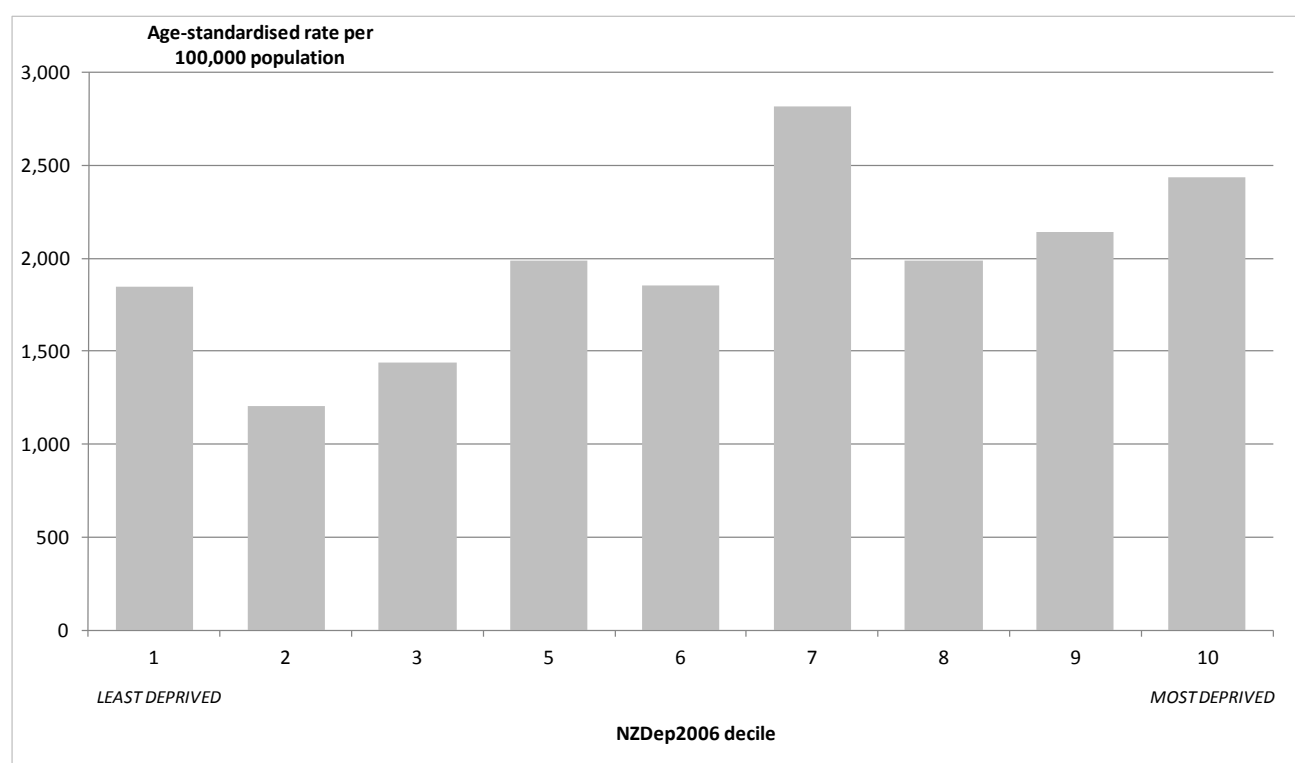
Neighbourhood deprivation (NZDep2006)

As noted earlier, the New Zealand Deprivation Index 2006 (NZDep2006) is a measure of the level of socioeconomic deprivation in small geographic areas ('neighbourhoods') of New Zealand, based on 2006 Census data. Decile 1 on the index refers to the least socioeconomically deprived 10% (decile) of New Zealand's neighbourhoods. Decile 10 refers to the most socioeconomically deprived 10% of New Zealand's neighbourhoods.

Figure 4.5 shows the age-standardised rates of injury hospitalisation for New Plymouth District people according to their NZDep2006 areas. In general, injury hospitalisation rates tended to be higher in the more deprived neighbourhoods of New Plymouth District (especially decile 7) and lower in the less deprived neighbourhoods (especially deciles 2 and 3).

Figure 4.5

Injury Hospitalisation New Plymouth District, by NZDep2006 decile Five years 2006–2010 combined



Source: Data supplied by Ministry of Health. Data in appendix table 4.8.

Note: Years are calendar years 1 January to 31 December.

Rates calculated using Statistics NZ 2006 Census data for New Plymouth District.

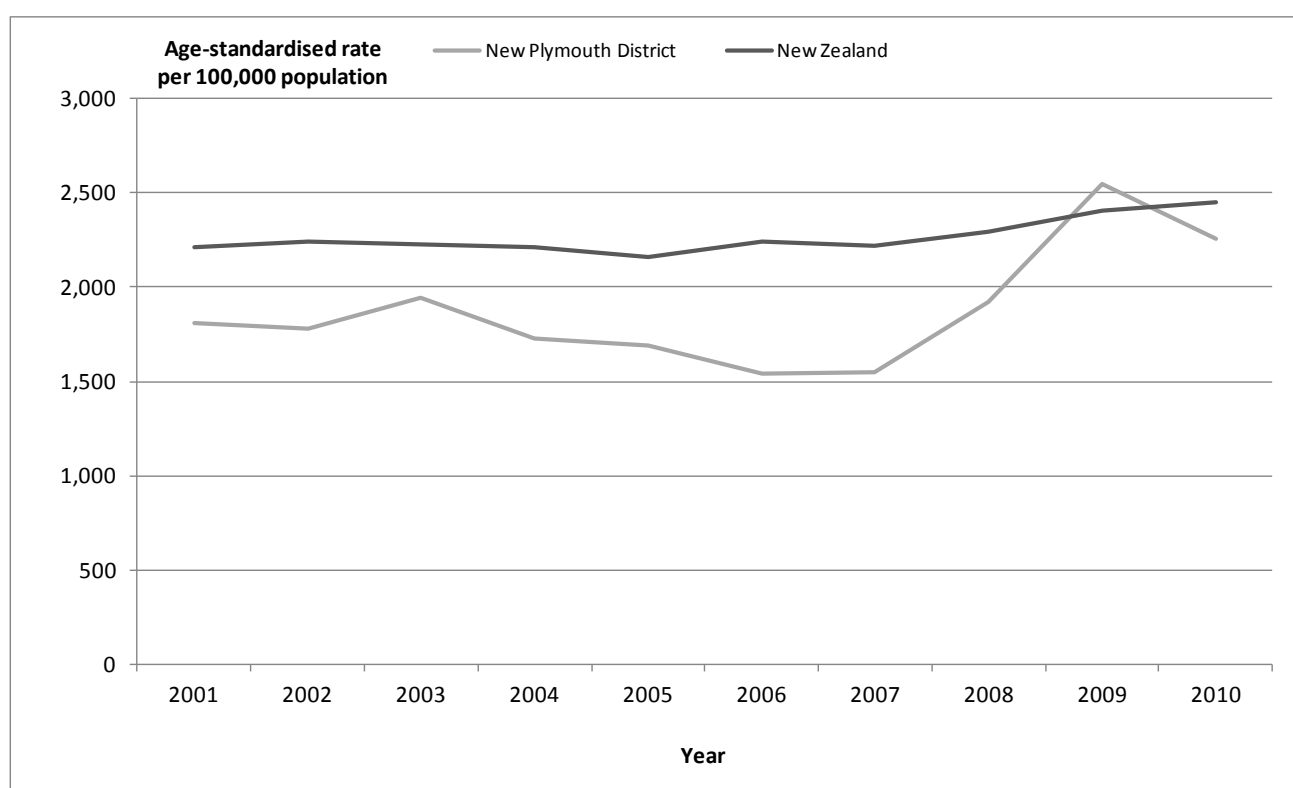
Age-standardised rates (ASRs) calculated using Segi world population.

Trends in injury hospitalisation (all causes)

Figure 4.6 traces New Plymouth District injury hospitalisation rates for each of the 10 years 2001–2010 compared to New Zealand rates. The New Plymouth District rate consistently tracked below the New Zealand rate from 2001 to 2007. After that the New Plymouth rate rose to be more in line with the national rate. Only in 2009 did the New Plymouth rate exceed the national rate.

Figure 4.6

Injury Hospitalisation (All Causes) New Plymouth District and New Zealand 2001–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.9.

Note: Years are calendar years 1 January to 31 December. ICD-10 E-codes used.

Trends in injury hospitalisation caused by falls

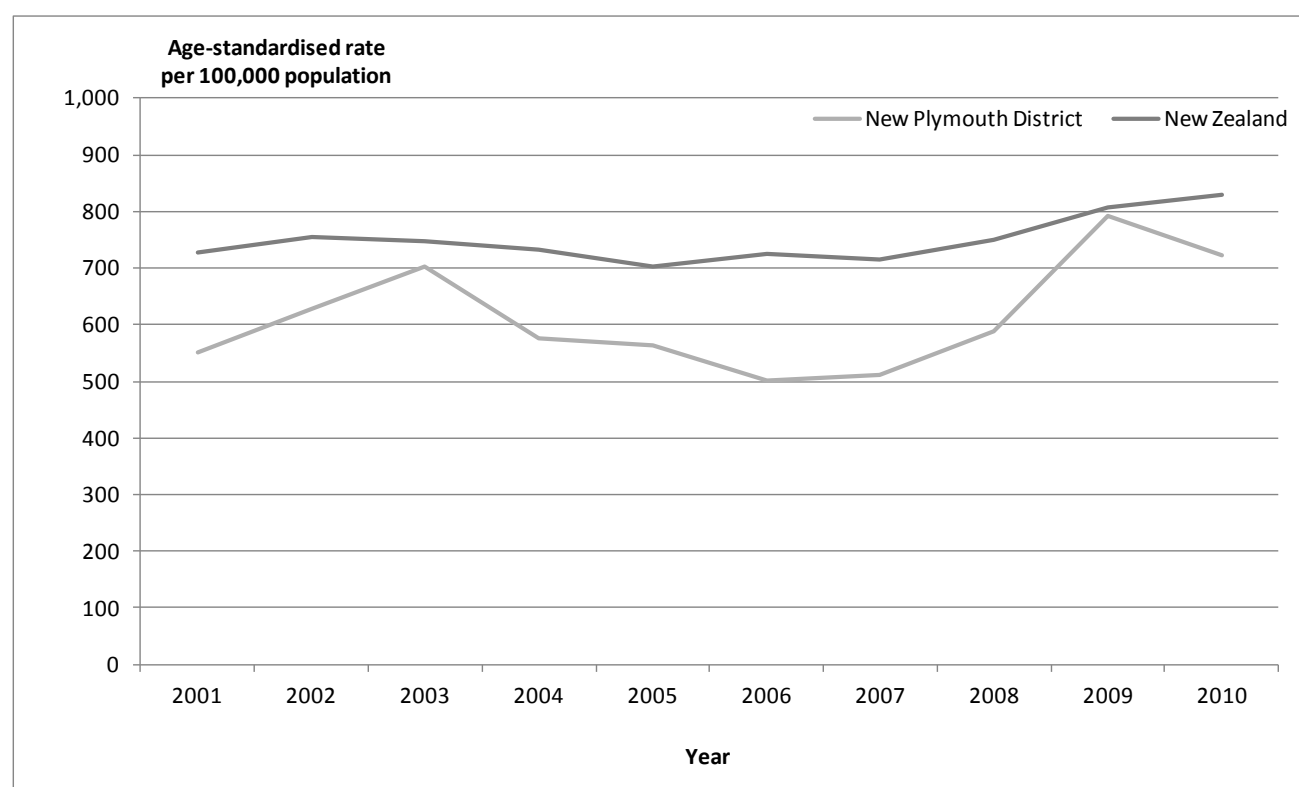
Figure 4.7 compares New Plymouth District and New Zealand all-age rates of injury hospitalisation caused by falls, for the 10 years 2001–2010. New Plymouth's fall injury hospitalisation rates were notably lower than New Zealand's in this period, especially between 2004 and 2008. New Plymouth's rate rose to be more in line with the national rate in 2009, but decreased again in 2010.

Figure 4.7

Injury Hospitalisation Caused by Falls

New Plymouth District and New Zealand

2001–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.9.

Note: Years are calendar years 1 January to 31 December. ICD-10 E-codes used.

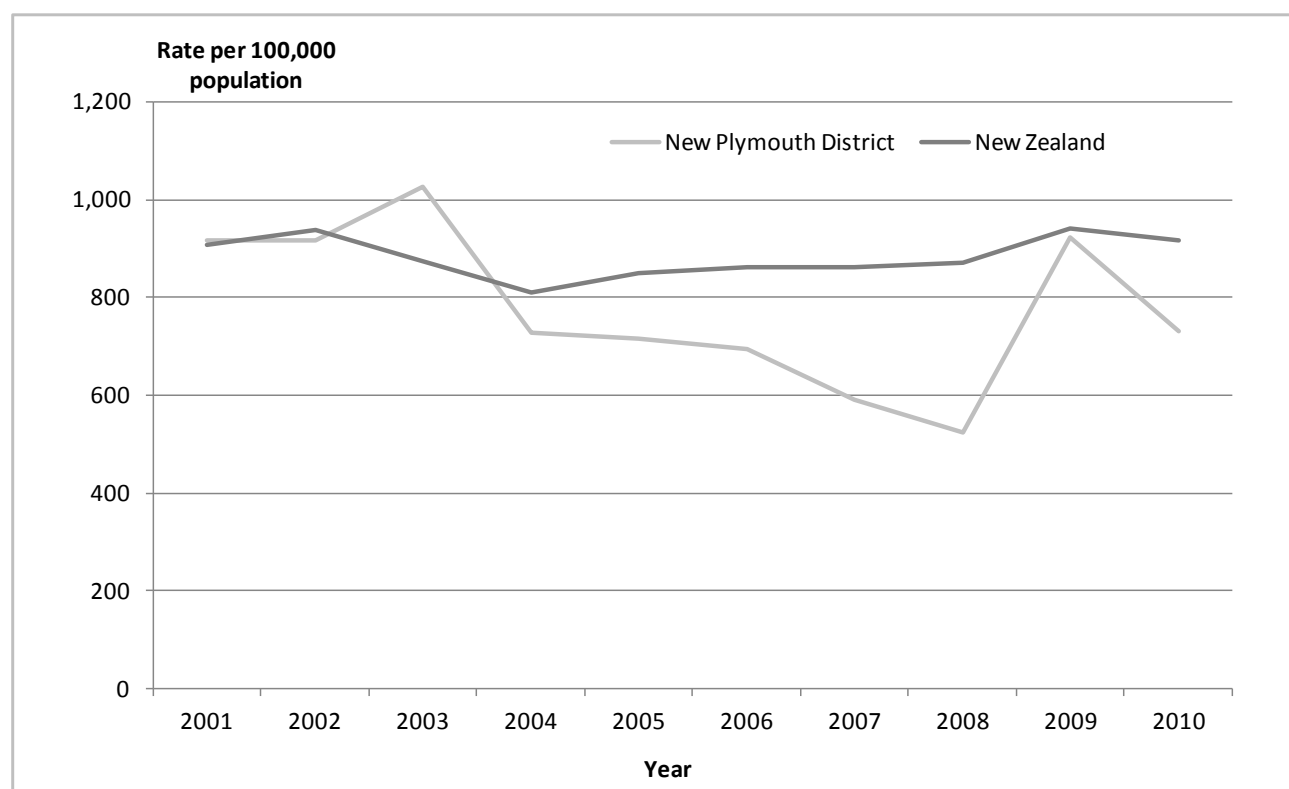
Trends in hospitalisations for falls among children

Looking in more detail at trends in hospitalisations for falls among younger children, from 2001–2003 New Plymouth District had rates that were similar, or slightly higher than New Zealand's. Then from 2004–2008, New Plymouth's rates decreased and were considerably lower than New Zealand's. However, the rates increased again in 2009 to almost the national level, before decreasing again in 2010 (figure 4.8).

Figure 4.8

Injury Hospitalisation Caused by Falls Among Children Aged 0–9

New Plymouth District and New Zealand
2001–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.10.

Note: Years are calendar years 1 January to 31 December. ICD-10 E-codes used.

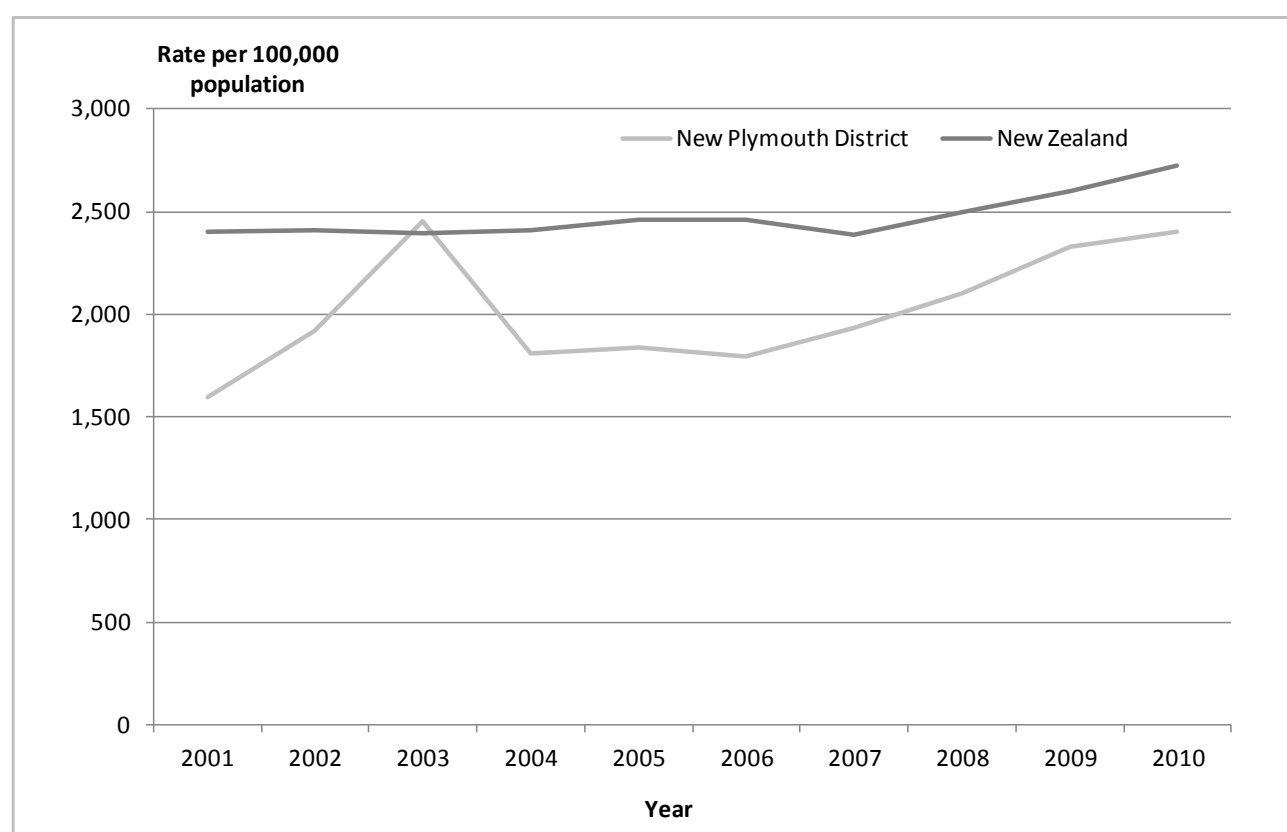
Trends in hospitalisations for falls among older adults

For nearly the whole decade 2001–2010, hospitalisation rates for falls among New Plymouth District people aged 70–79 (figure 4.9) and 80+ (figure 4.10 overleaf) were lower than the national average. The only exception was in 2003 when New Plymouth’s rate for people aged 70–79 spiked to be slightly higher than New Zealand’s.

There was a gradual increase in fall hospitalisation rates for people aged 70 and over as the decade progressed, both in New Plymouth and New Zealand.

Figure 4.9

Injury Hospitalisation Caused by Falls Among Adults Aged 70–79
New Plymouth District and New Zealand
2001–2010

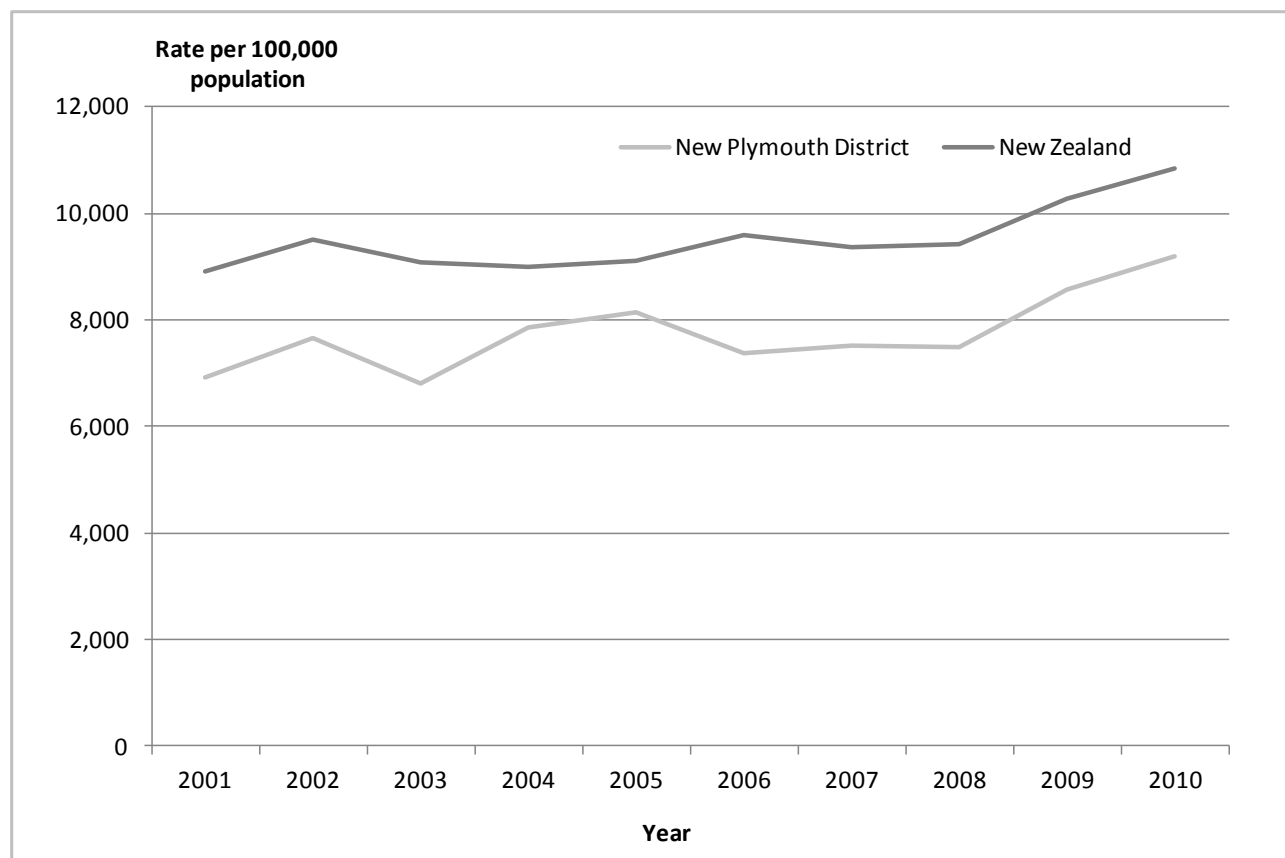


Source: Data supplied by Ministry of Health. Data in appendix table 4.10.

Note: Years are calendar years 1 January to 31 December. ICD-10 E-codes used.

Figure 4.10

Injury Hospitalisation Caused by Falls Among Adults Aged 80+
New Plymouth District and New Zealand
 2001–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.10.

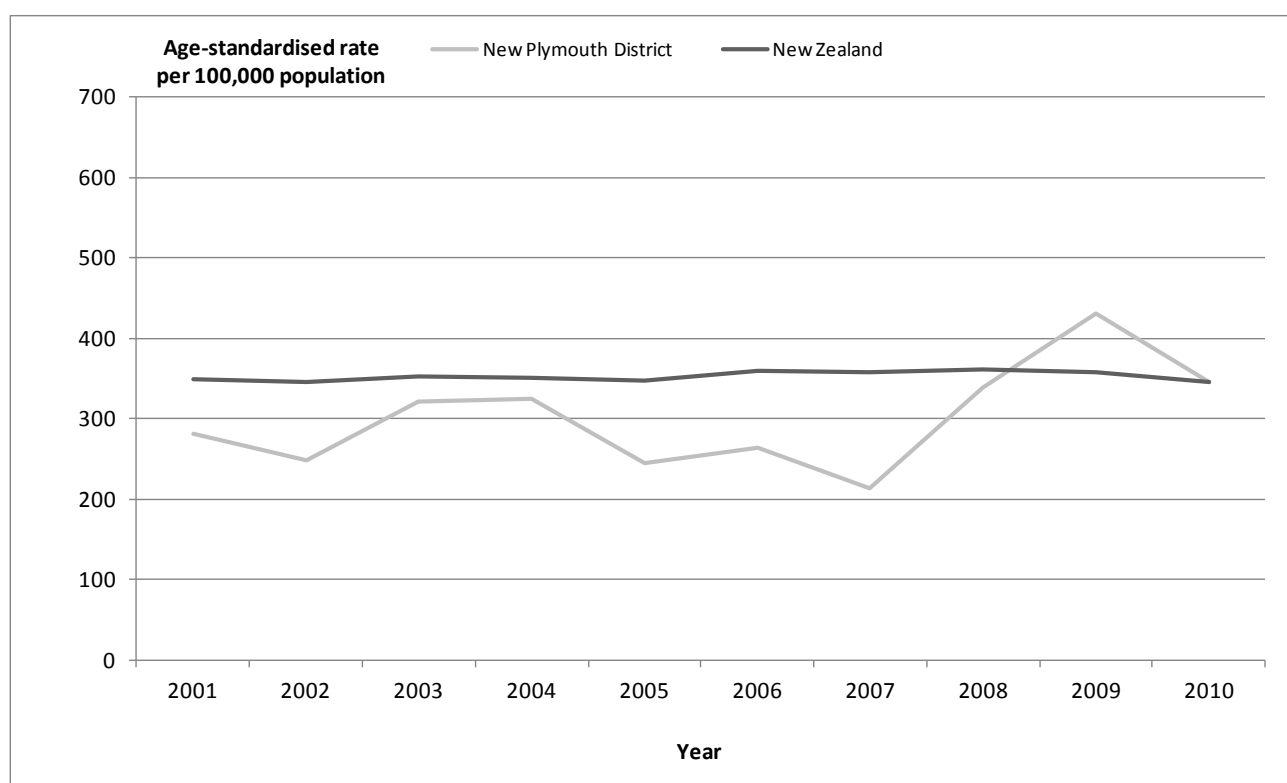
Note: Years are calendar years 1 January to 31 December. ICD-10 E-codes used.

Trends in injury hospitalisation caused by transport accidents

Figure 4.11 compares New Plymouth District and New Zealand rates of injury hospitalisation caused by transport accidents for the 10 years 2001–2010. Until 2008, New Plymouth District's transport accident hospitalisation rates tracked below New Zealand's. In 2009 New Plymouth's rate was higher than New Zealand's and in 2010 the rate was the same as New Zealand's.

Figure 4.11

Injury Hospitalisation Caused by Transport Accidents New Plymouth District and New Zealand 2001–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.9.

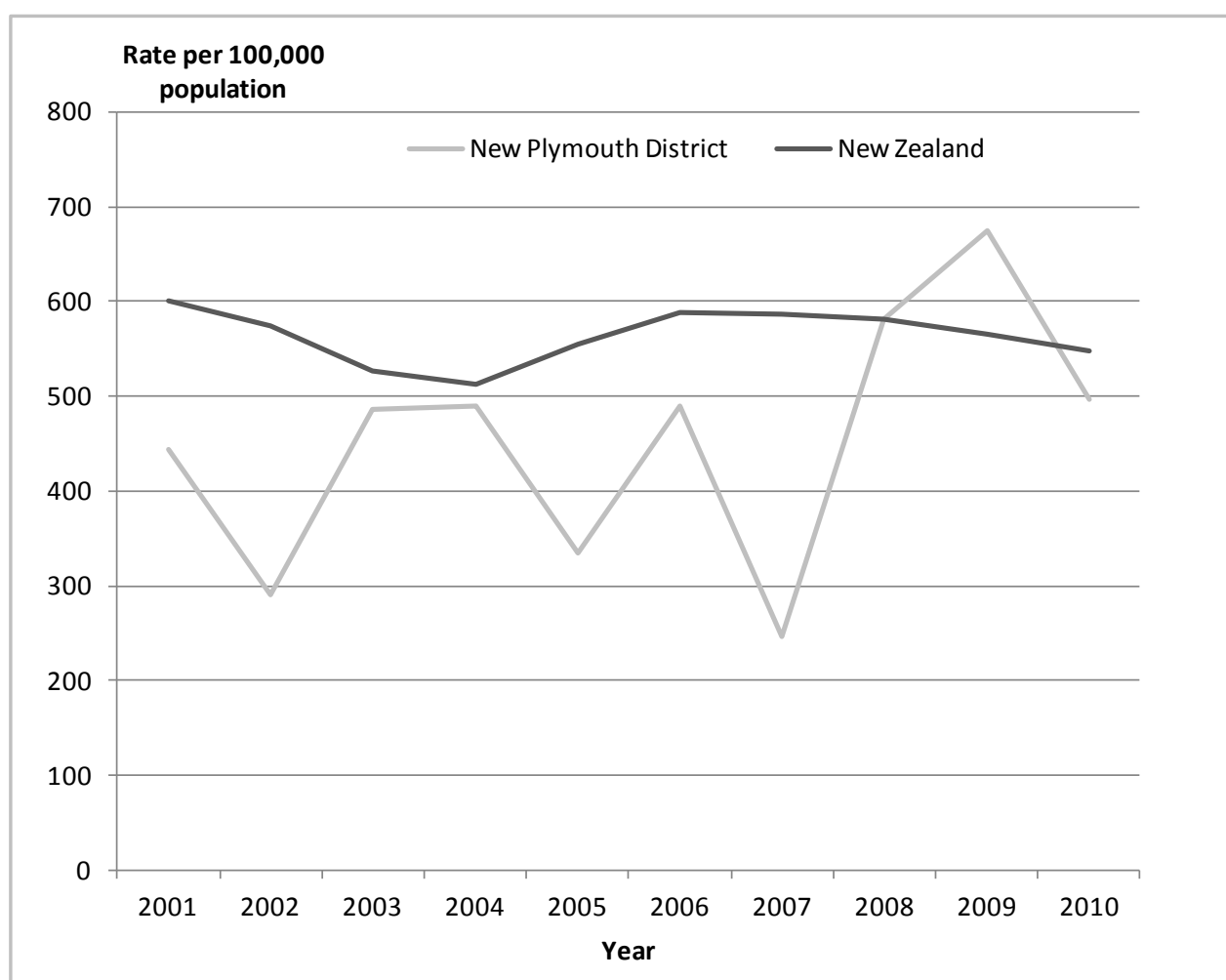
Note: Years are calendar years 1 January to 31 December. ICD-10 E-codes used.

Trends in hospitalisations for transport accidents among young adults

Looking at trends in hospitalisations for transport accidents among teenagers and younger adults aged 15–29; from 2001–2007 New Plymouth District's rates fluctuated considerably but were below New Zealand's rates. In 2008 New Plymouth's rates increased to a rate similar to New Zealand's and continued to rise in 2009 to higher than the national rate. In 2010 there was another decrease so that New Plymouth's rates were again slightly lower than New Zealand's (figure 4.12).

Figure 4.12

Injury Hospitalisation Caused by Transport Accidents Among Adults Aged 15–29 New Plymouth District and New Zealand 2001–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.11.

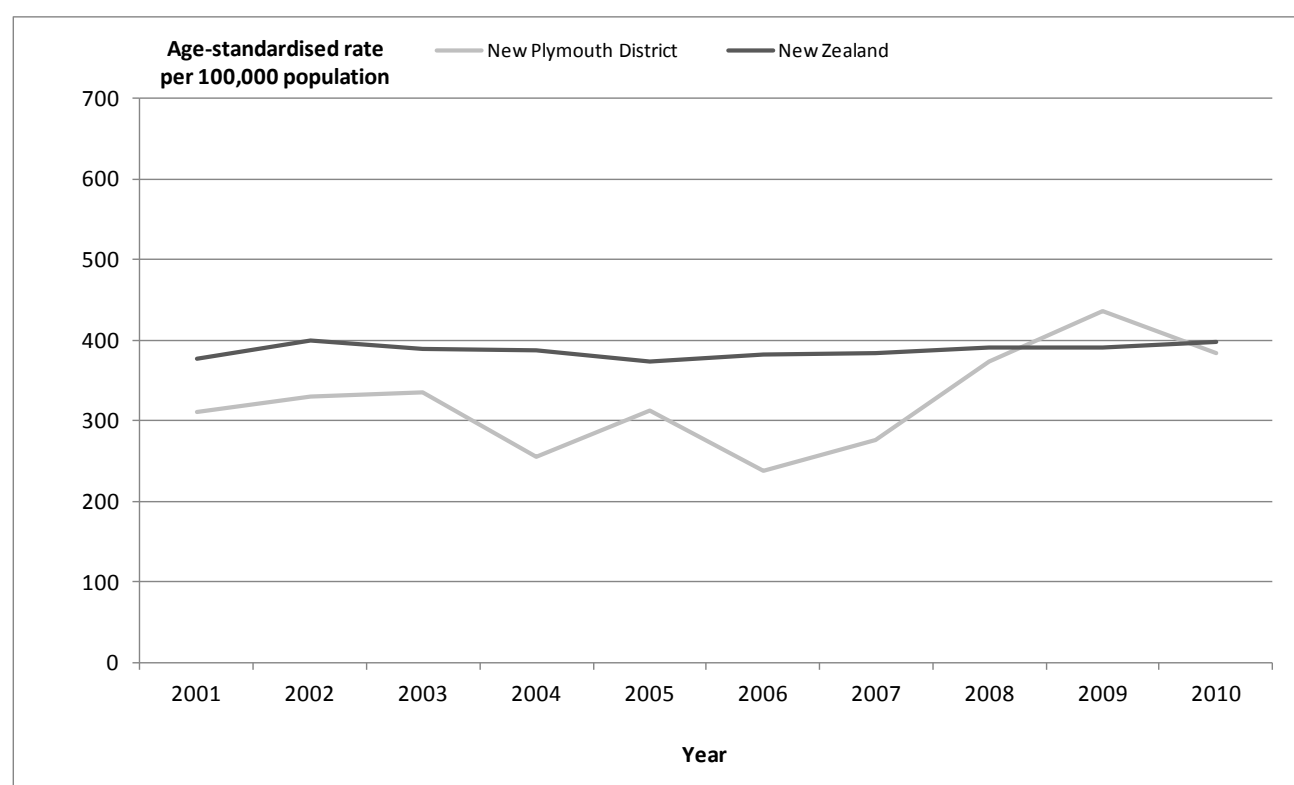
Note: Years are calendar years 1 January to 31 December. ICD-10 E-codes used.

Trends in injury hospitalisation caused by inanimate mechanical forces

Figure 4.13 compares New Plymouth District and New Zealand rates of injury hospitalisation caused by exposure to inanimate mechanical forces, for the 10 years 2001–2010. New Plymouth District's rates tracked below New Zealand's consistently until 2008. In 2009 the New Plymouth rate was higher than New Zealand's and in 2010 it was slightly lower.

Figure 4.13

Injury Hospitalisation Caused by Exposure to Inanimate Mechanical Forces New Plymouth District and New Zealand 2001–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.9.

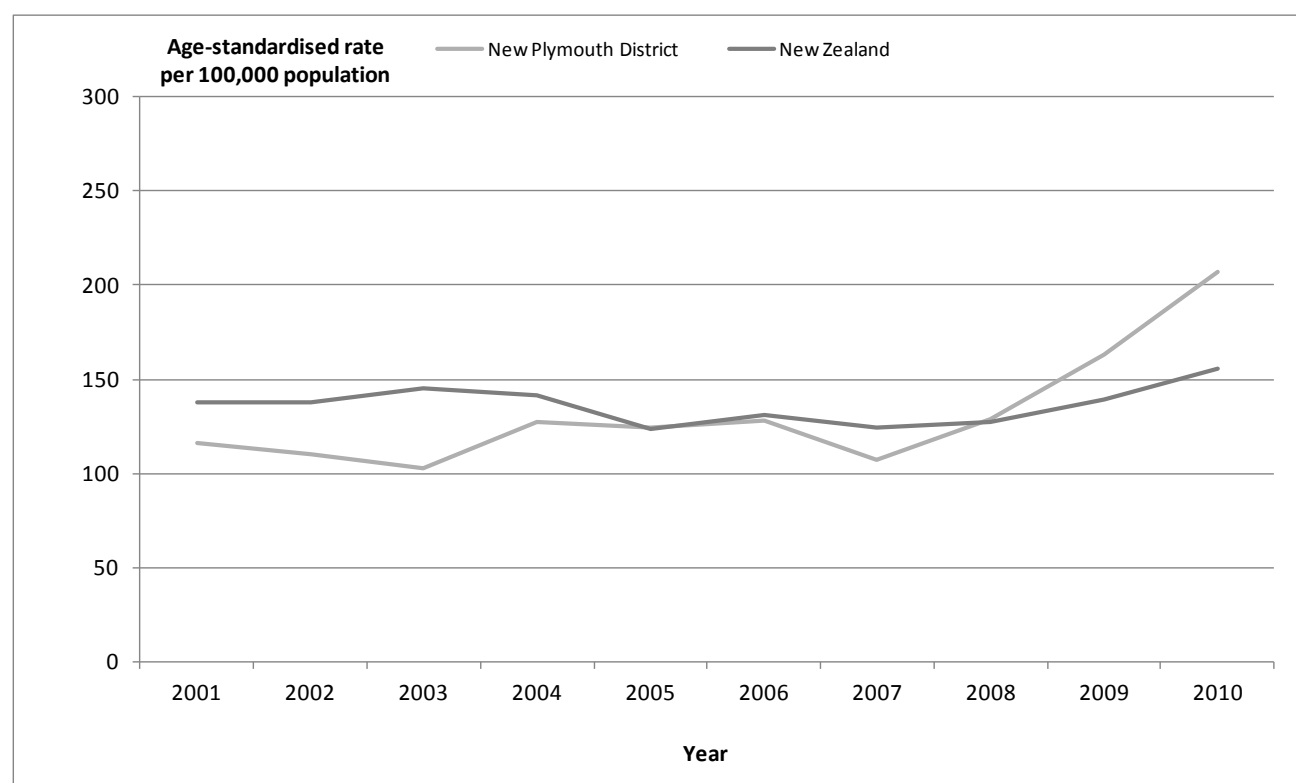
Note: Years are calendar years 1 January to 31 December. ICD-10 E-codes used.

Trends in injury hospitalisation caused by intentional self-harm

Figure 4.14 compares New Plymouth District and New Zealand's intentional self-harm injury hospitalisation rates for the 10 years 2001–2010. New Plymouth's rates tracked below or were similar to New Zealand's from 2001 to 2007 and were above New Zealand's in 2009 and 2010. Between 2007 and 2010 New Plymouth's rates essentially doubled.

Figure 4.14

Injury Hospitalisation Caused by Intentional Self-harm New Plymouth District and New Zealand 2001–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.9.

Note: Years are calendar years 1 January to 31 December. ICD-10 E-codes used.

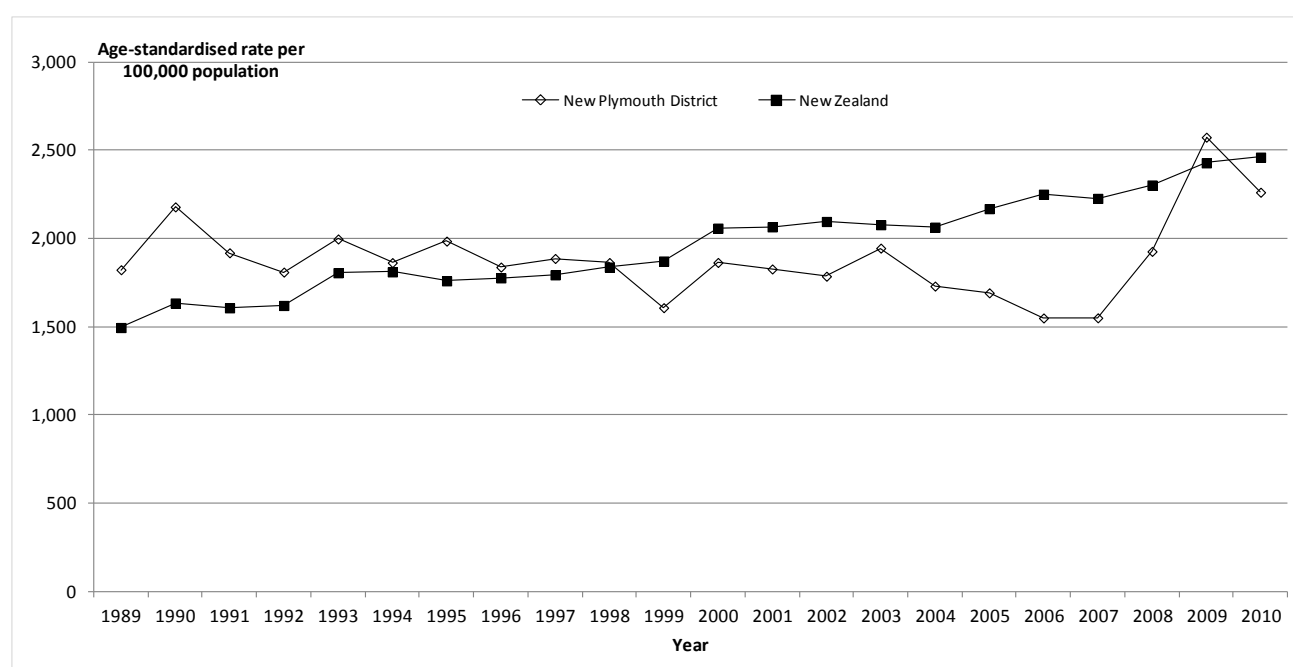
Long-term trends in injury hospitalisation – all people, all ages

Figure 4.15 compares New Plymouth District and New Zealand rates of injury hospitalisation for people of all ages over the 22 years 1989–2010. The rates are age-standardised to control for differences in the age structure of the New Plymouth District and New Zealand populations.

New Plymouth District's all-age injury hospitalisation rates generally tracked downwards throughout the period to 2007. By contrast, New Zealand's slowly but steadily tracked upwards. In 2009 New Plymouth's rates spiked to be higher than New Zealand's for the first time since 1997. This is in contrast to 2006 and 2007 when New Plymouth's rates were the lowest recorded in the entire 22 year period.

Figure 4.15

Injury Hospitalisation Rates for All People, All Ages New Plymouth District and New Zealand 1989–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.12.

Note: Years are calendar years 1 January to 31 December.
Rates calculated using ICD-9 codes. Years 2001–2010 back-coded from ICD-10.
Age-standardised rates (ASRs) calculated using Segi world population.

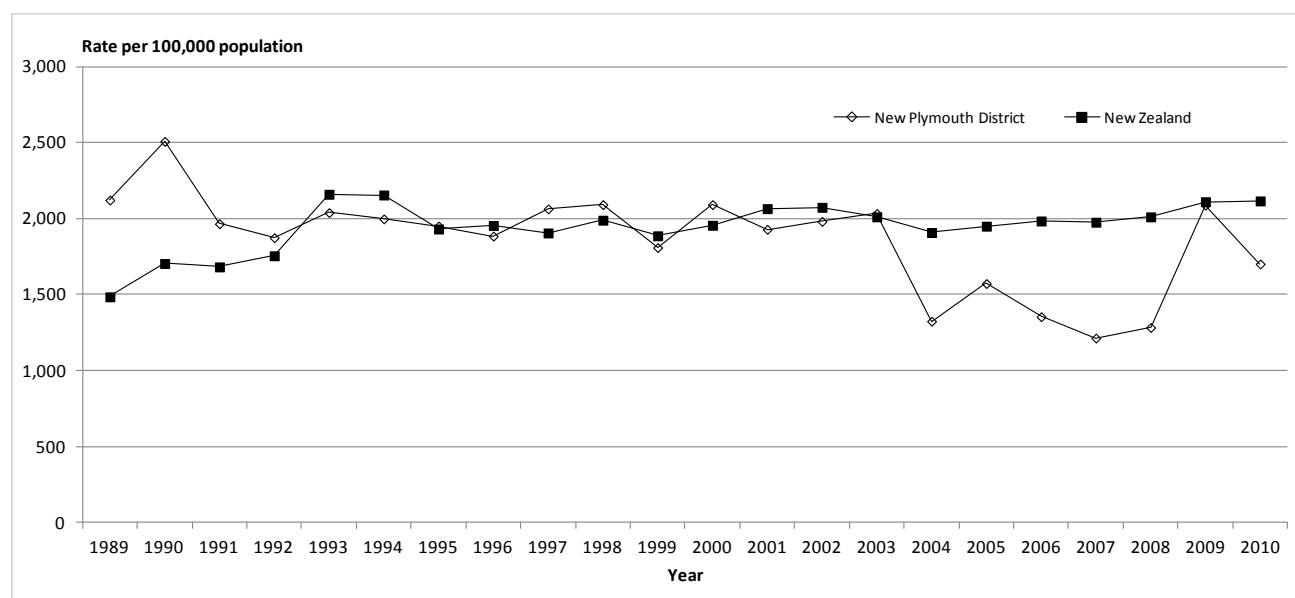
Long-term trends in injury hospitalisation – children aged 0–9

Figure 4.16 compares New Plymouth District and New Zealand rates of injury hospitalisation for children aged 0–9 over the 22 years 1989–2010.

While local rates were higher than New Zealand's in the early 1990s, they became similar during the rest of the 1990s until 2003. From 2004 onwards (apart from 2009) they were lower than the national rates.

Figure 4.16

Injury Hospitalisation Rate for Children Aged 0–9 New Plymouth District and New Zealand 1989–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.12.

Note: Years are calendar years 1 January to 31 December.
Rates calculated using ICD-9 codes. Years 2001–2010 back-coded from ICD-10.

Long-term trends in injury hospitalisation – young people aged 10–19

Figure 4.17 compares New Plymouth District and New Zealand rates of injury hospitalisation for young people aged 10–19 over the 22 years 1989–2010.

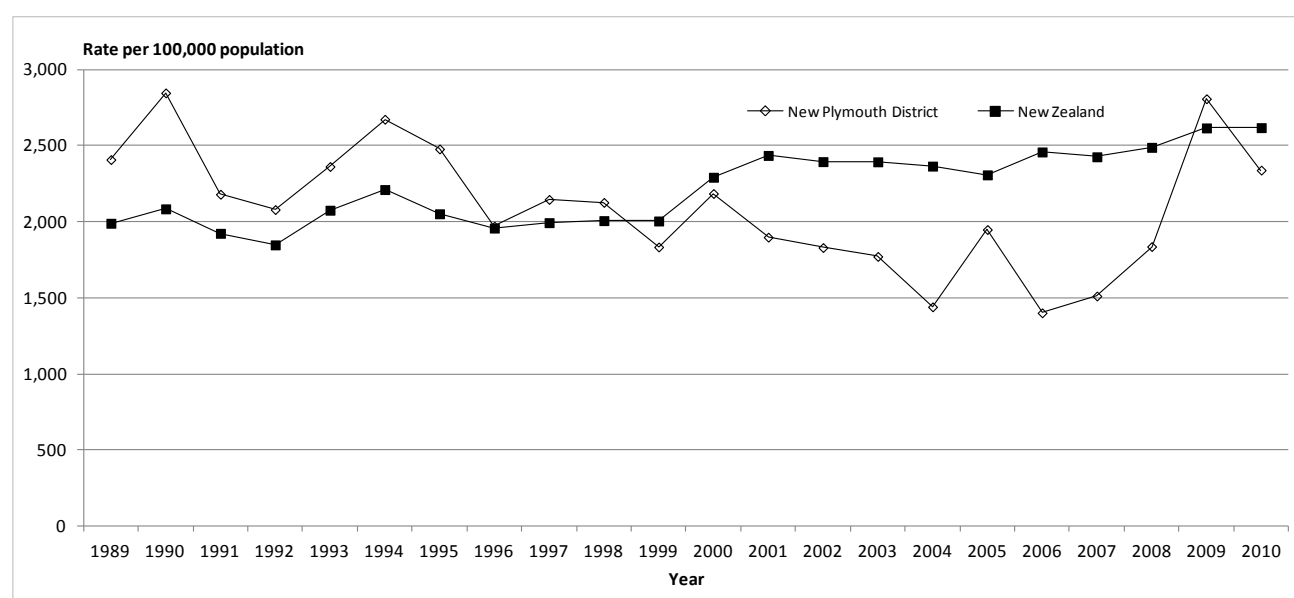
From 1989 to 1998, local rates of injury hospitalisation were higher than the national rates. However, from 1999 onwards, local rates were lower than the national average (apart from in 2009).

Figure 4.17

Injury Hospitalisation Rate for Young People Aged 10–19

New Plymouth District and New Zealand

1989–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.12.

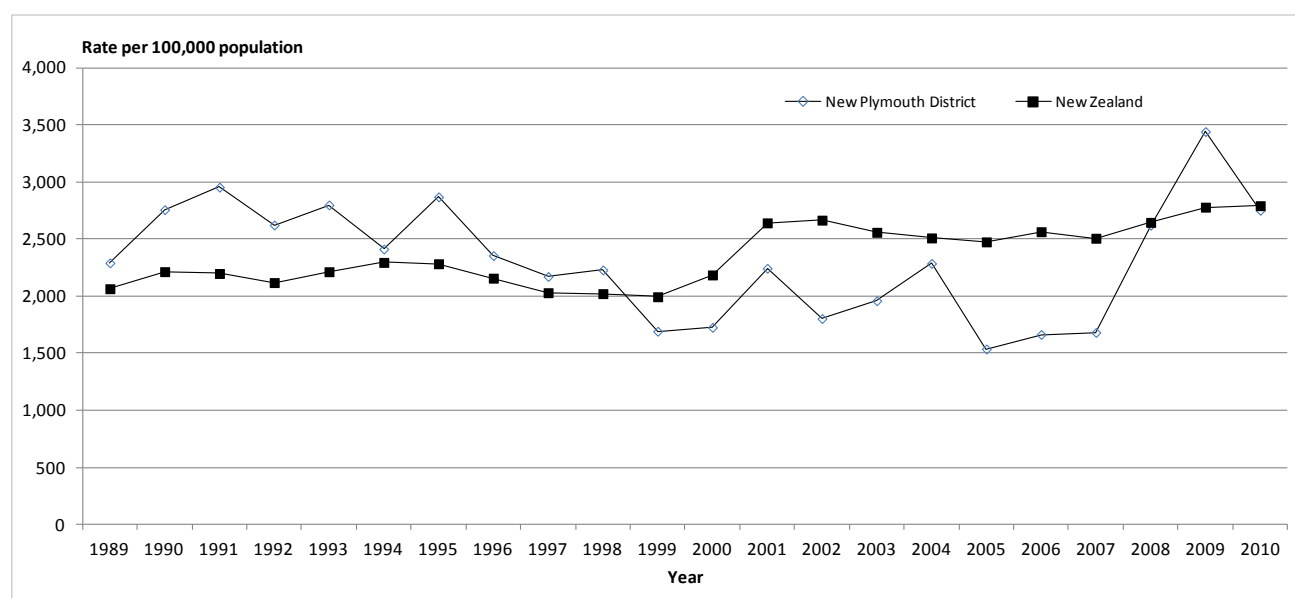
Note: Years are calendar years 1 January to 31 December.
Rates calculated using ICD-9 codes. Years 2001–2010 back-coded from ICD-10.

Long-term trends in injury hospitalisation – adults aged 20–29

Figure 4.18 compares New Plymouth District and New Zealand rates of injury hospitalisation for adults aged 20–29 over the 22 years 1989–2010. For the first decade 1989–1998, New Plymouth's rates were higher than New Zealand's. After that they were lower, apart from 2009 when the rate was higher.

Figure 4.18

Injury Hospitalisation Rate for Adults Aged 20–29 New Plymouth District and New Zealand 1989–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.12.

Note: Years are calendar years 1 January to 31 December.
Rates calculated using ICD-9 codes. Years 2001–2010 back-coded from ICD-10.

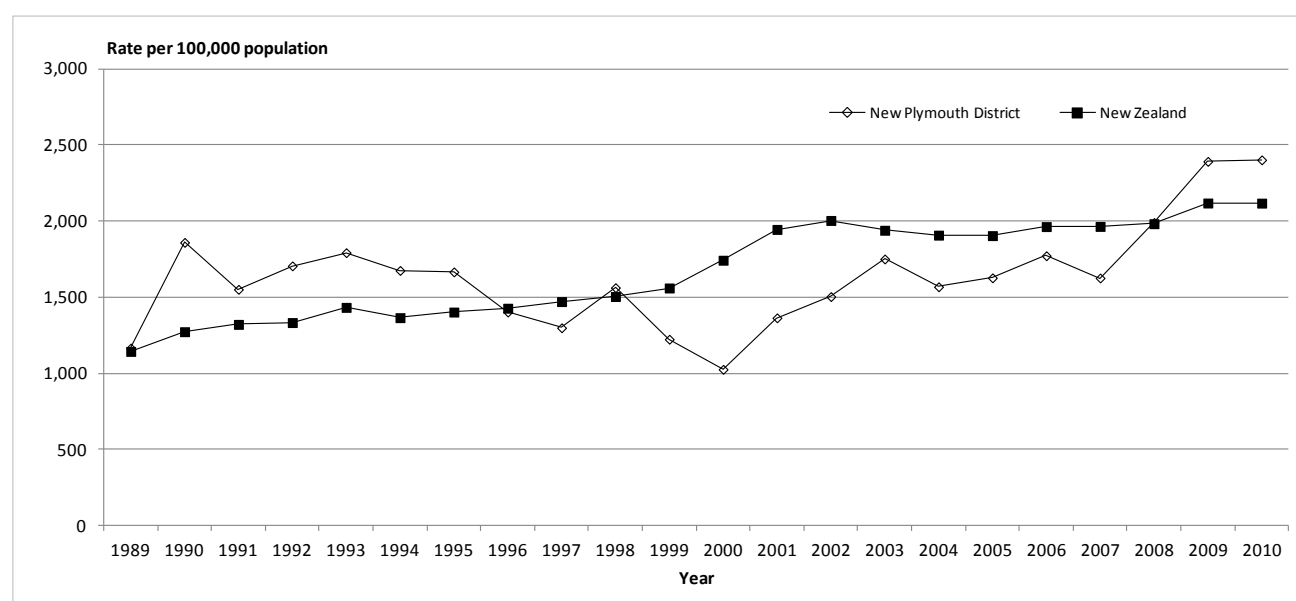
Long-term trends in injury hospitalisation – adults aged 30–39

Figure 4.19 compares New Plymouth District and New Zealand rates of injury hospitalisation for adults aged 30–39 over the 22 years 1989–2010.

Trends for 30–39 year olds were similar to those for 20–29 year olds, except local rates remained higher than the national average in 2010.

Figure 4.19

Injury Hospitalisation Rate for Adults Aged 30–39 New Plymouth District and New Zealand 1989–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.12.

Note: Years are calendar years 1 January to 31 December.
Rates calculated using ICD-9 codes. Years 2001–2010 back-coded from ICD-10.

Long-term trends in injury hospitalisation – adults aged 40–49

Figure 4.20 compares New Plymouth District and New Zealand rates of injury hospitalisation for adults aged 40–49 over the 22 years 1989–2010.

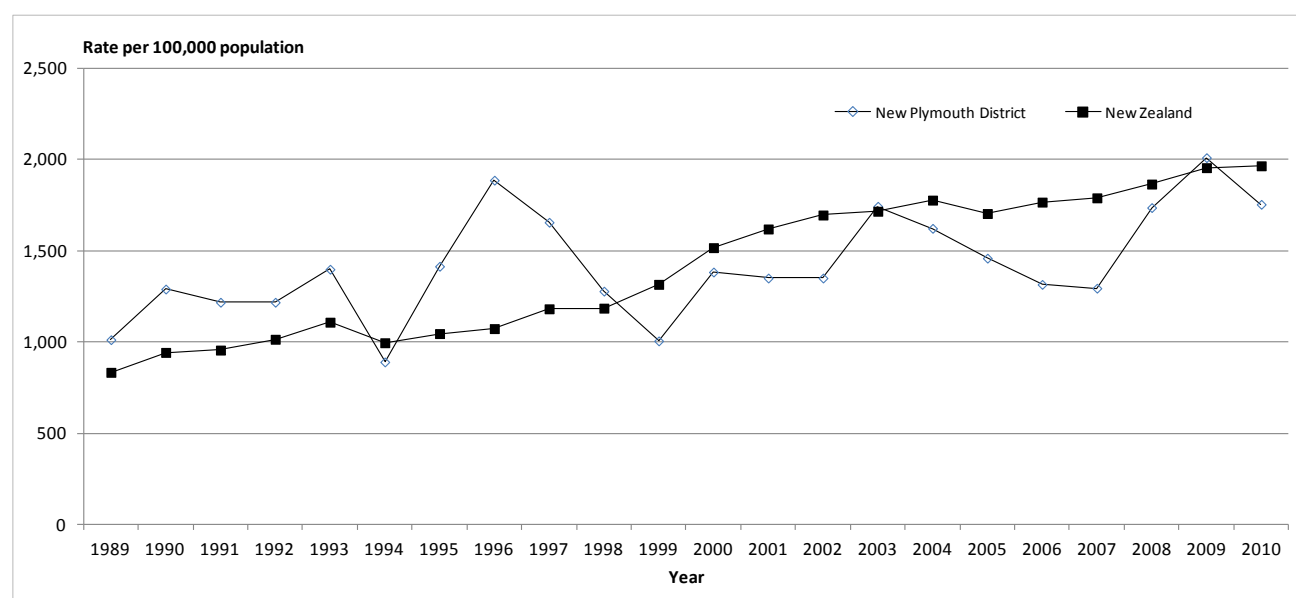
Again, local injury hospitalisation rates were higher than national rates before 1999 (except in 1994 when the rate was slightly lower). From 1999 onwards New Plymouth's rates were lower than New Zealand's, except in 2003 and 2009 when both rates were similar.

Figure 4.20

Injury Hospitalisation Rate for Adults Aged 40–49

New Plymouth District and New Zealand

1989–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.12.

Note: Years are calendar years 1 January to 31 December.
Rates calculated using ICD-9 codes. Years 2001–2010 back-coded from ICD-10.

Long-term trends in injury hospitalisation – adults aged 50–59

Figure 4.21 compares New Plymouth District and New Zealand rates of injury hospitalisation for adults aged 50–59 over the 22 years 1989–2010.

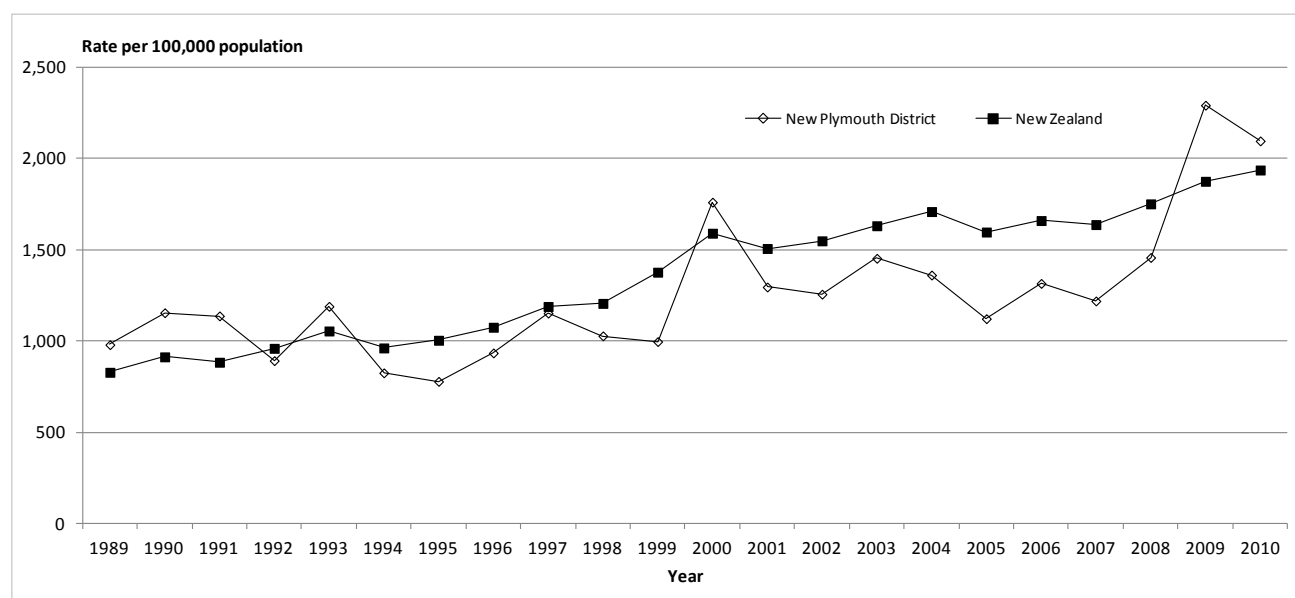
In the early 1990s, New Plymouth's rates were slightly higher than New Zealand's. From 1994 to 2008 they were lower (apart from a spike in the year 2000). In 2009 and 2010 local rates were higher than national rates.

Figure 4.21

Injury Hospitalisation Rate for Adults Aged 50–59

New Plymouth District and New Zealand

1989–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.12.

Note: Years are calendar years 1 January to 31 December.

Rates calculated using ICD-9 codes. Years 2001–2010 back-coded from ICD-10.

Long-term trends in injury hospitalisation – adults aged 60–69

Figure 4.22 compares New Plymouth District and New Zealand rates of injury hospitalisation for adults aged 60–69 over the 22 years 1989–2010.

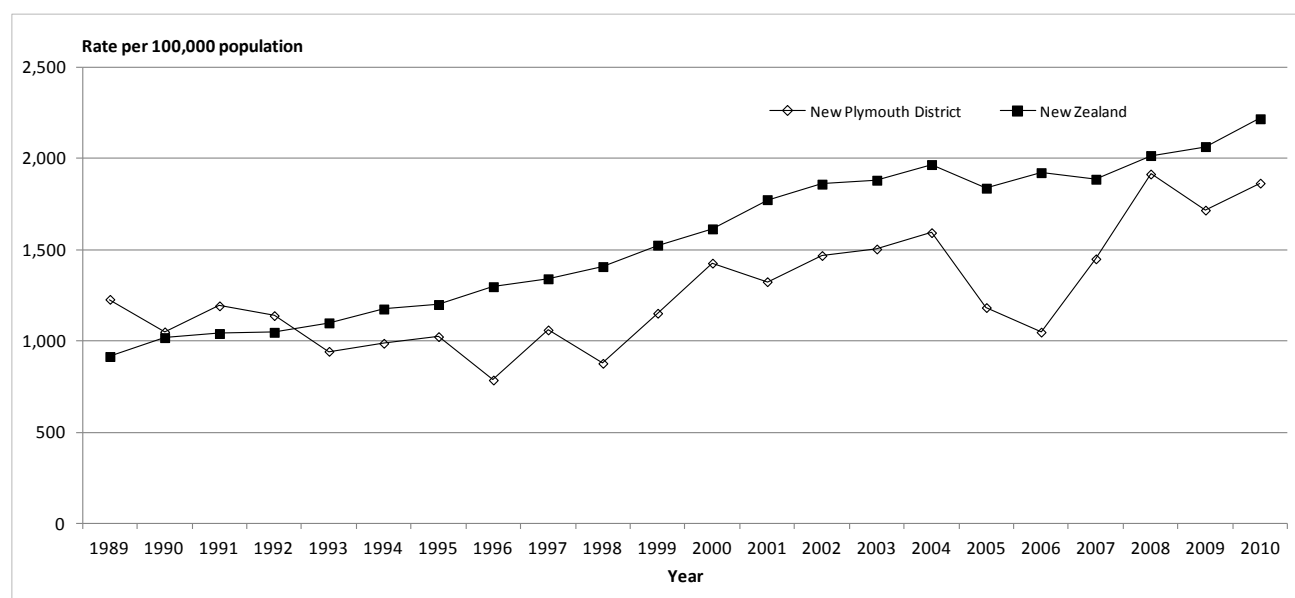
From 1989–1992, New Plymouth's rates were slightly higher than New Zealand's. Throughout 1993–2010 they were consistently below New Zealand's.

Figure 4.22

Injury Hospitalisation Rate for Adults Aged 60–69

New Plymouth District and New Zealand

1989–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.12.

Note: Years are calendar years 1 January to 31 December.
Rates calculated using ICD-9 codes. Years 2001–2010 back-coded from ICD-10.

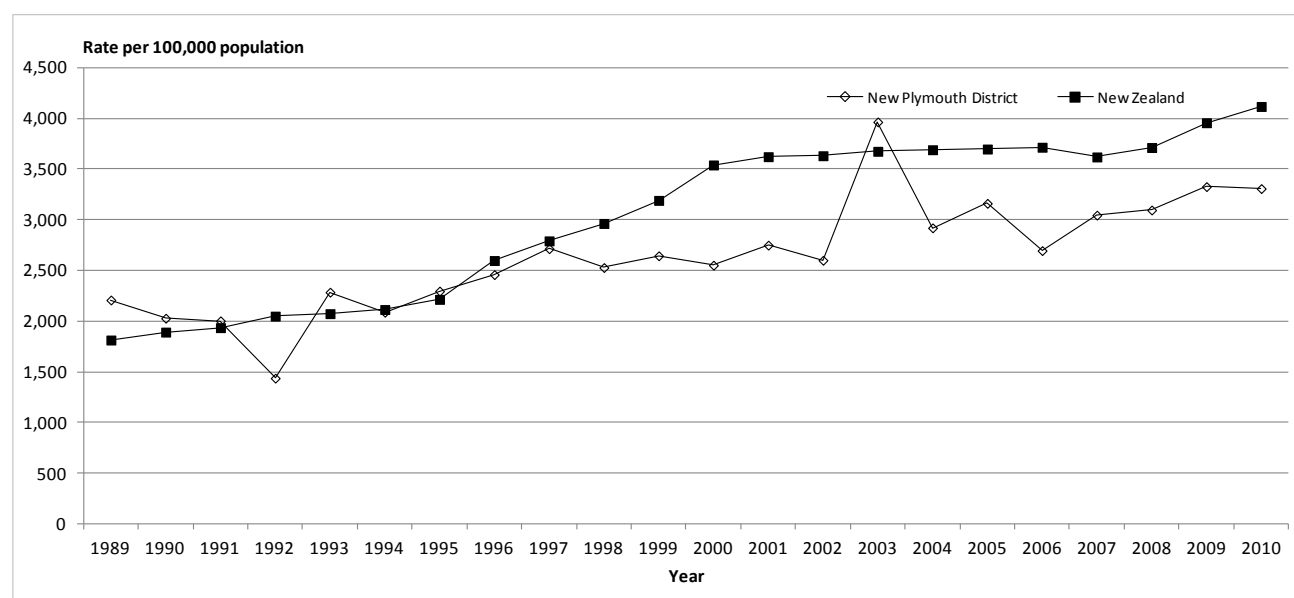
Long-term trends in injury hospitalisation – adults aged 70–79

Figure 4.23 compares New Plymouth District and New Zealand rates of injury hospitalisation for adults aged 70–79 over the 22 years 1989–2010.

Trends in rates for 70–79 year olds were similar to those for 60–69 year olds, except for a spike in local rates in 2003 which was slightly above the national rate.

Figure 4.23

Injury Hospitalisation Rate for Adults Aged 70–79 New Plymouth District and New Zealand 1989–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.12.

Note: Years are calendar years 1 January to 31 December.
Rates calculated using ICD-9 codes. Years 2001–2010 back-coded from ICD-10.

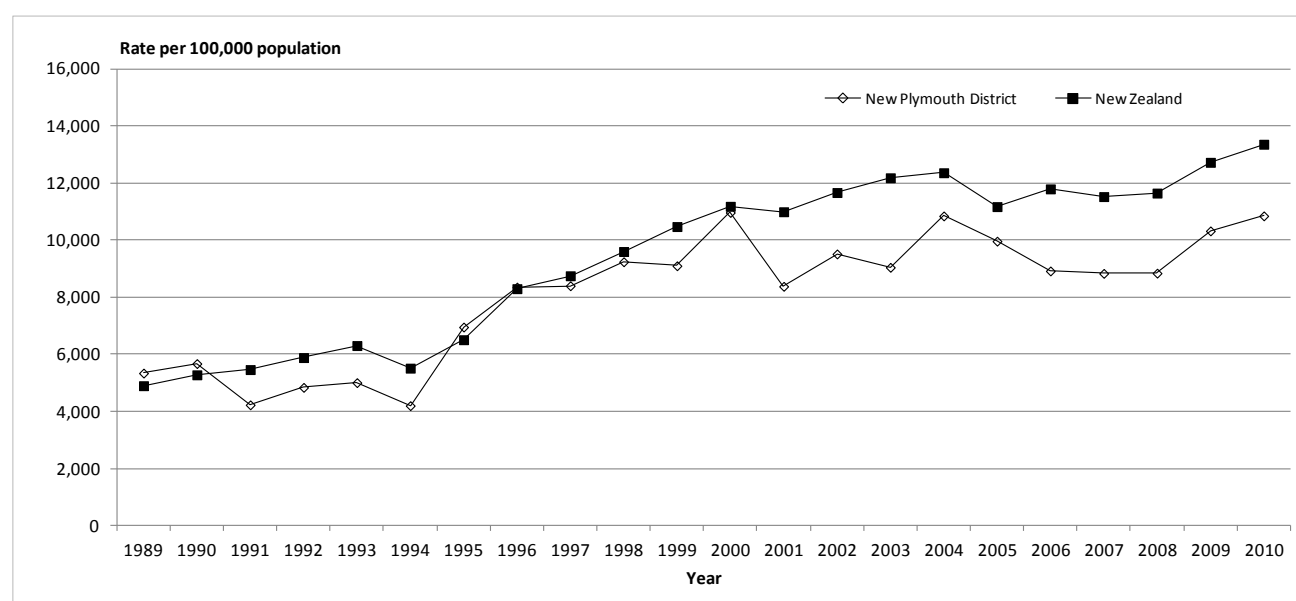
Long-term trends in injury hospitalisation – adults aged 80+

Figure 4.24 compares New Plymouth District and New Zealand rates of injury hospitalisation for adults aged 80+ over the 22 years 1989–2010.

From 1989–2000, local rates in the oldest age-group were similar or slightly below the national rates. From 2001–2010 local rates were consistently lower than New Zealand's.

Figure 4.24

Injury Hospitalisation Rate for Adults Aged 80+ New Plymouth District and New Zealand 1989–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.12.

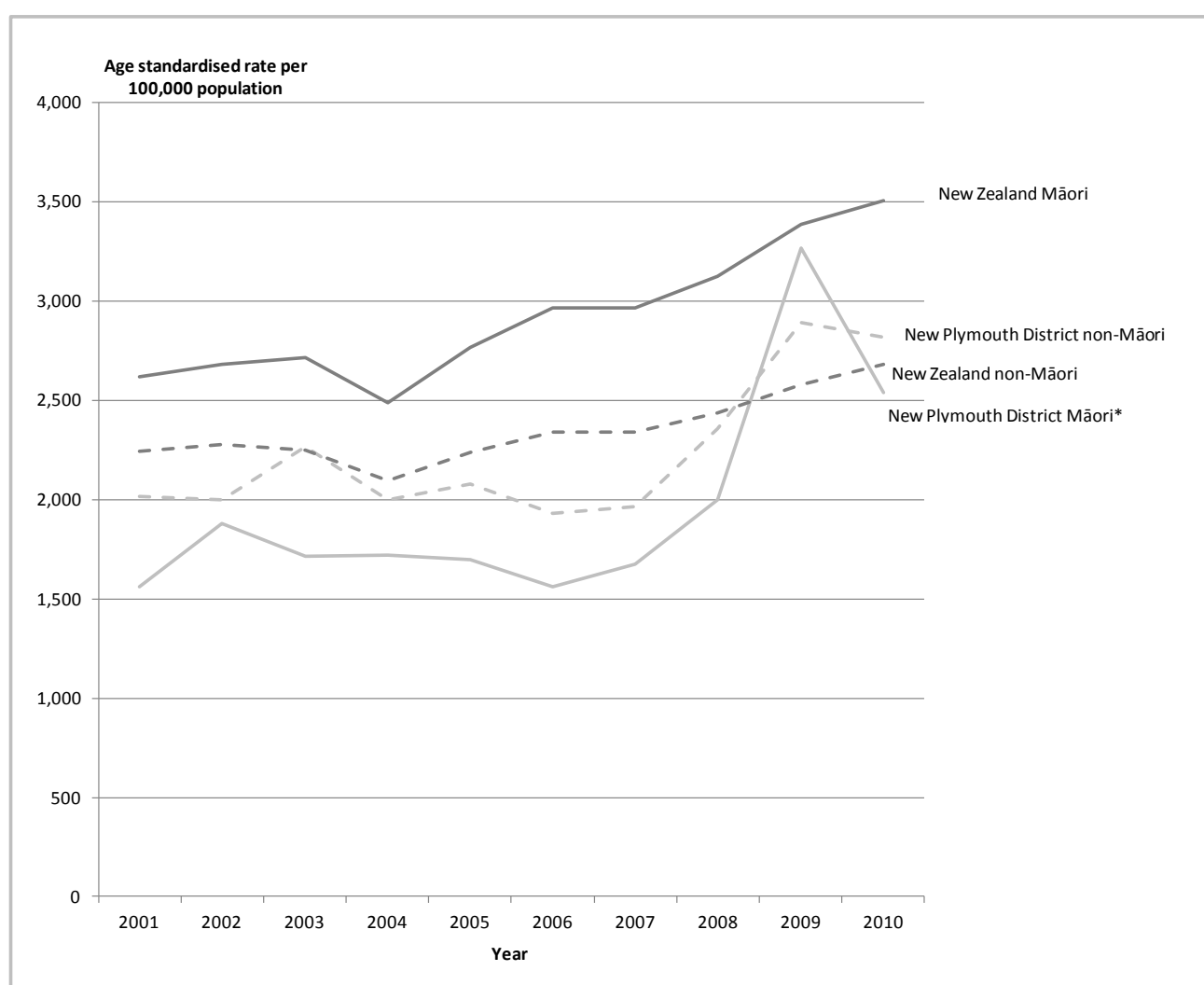
Note: Years are calendar years 1 January to 31 December.
Rates calculated using ICD-9 codes. Years 2001–2010 back-coded from ICD-10.

Trends in injury hospitalisations for Māori and non-Māori

Looking at annual trends in injury hospitalisations for Māori and non-Māori over the period 2001–2010, there was an overall increase in age-standardised rates for both New Plymouth District and New Zealand as a whole (figure 4.25).

Figure 4.25

Injury Hospitalisation for Māori and non-Māori – age-standardised rates New Plymouth District and New Zealand 2001–2010



Source: Data supplied by Ministry of Health. Data in appendix table 4.13.

Note: Years are calendar years 1 January to 31 December.

***Caution:** some age-specific rates for this group are based on relatively small numbers.

Until 2008, injury hospitalisation rates for New Plymouth District Māori were less than for local non-Māori.

In addition, compared with New Zealand Māori, New Plymouth District Māori had considerably lower rates of hospitalisation for injury until 2009 when their rates increased steeply and almost reached the national average. In 2010 the injury hospitalisation rate for local Māori decreased to become again considerably lower than the rate for all Māori in New Zealand.

From 2001–2007, age-standardised rates for injury hospitalisations among New Plymouth District non-Māori were somewhat lower than the national average for non-Māori, although the gap in rates was not as wide as it was for Māori.

In 2008, the rates for New Plymouth District non-Māori increased to reach almost national levels and in 2009 peaked at above the rate for New Zealand. In 2010 there was a slight decline in the rate for local non-Māori, but it was still slightly above the national average.

5

EMERGENCY DEPARTMENT ATTENDANCES

The Taranaki District Health Board has emergency departments at Taranaki Base Hospital in New Plymouth and Hawera Hospital. This chapter presents data on the 7,666 visits ('attendances') made by New Plymouth District residents to these hospital emergency departments for injury treatment in calendar year 2010.

In general, most emergency department (ED) visits for injury are for less-serious injuries. Normally these injuries are treated by ED staff without the patient being admitted to hospital. However, a proportion of ED visits are for serious injuries resulting in either a hospital admission, death or both.

Some New Plymouth District residents with less-serious injuries will not be seen at public hospital EDs. Instead they will be treated by other health services in the region such as private accident and emergency clinics, general practitioners and other health professionals. Data on injury cases from private A&E clinics and GPs are not publicly available and therefore are not included in this report.

National data for emergency department attendances are also not available, so comparisons with the rest of New Zealand cannot be made in this chapter.

Injury and non-injury Emergency Department Attendances in 2010

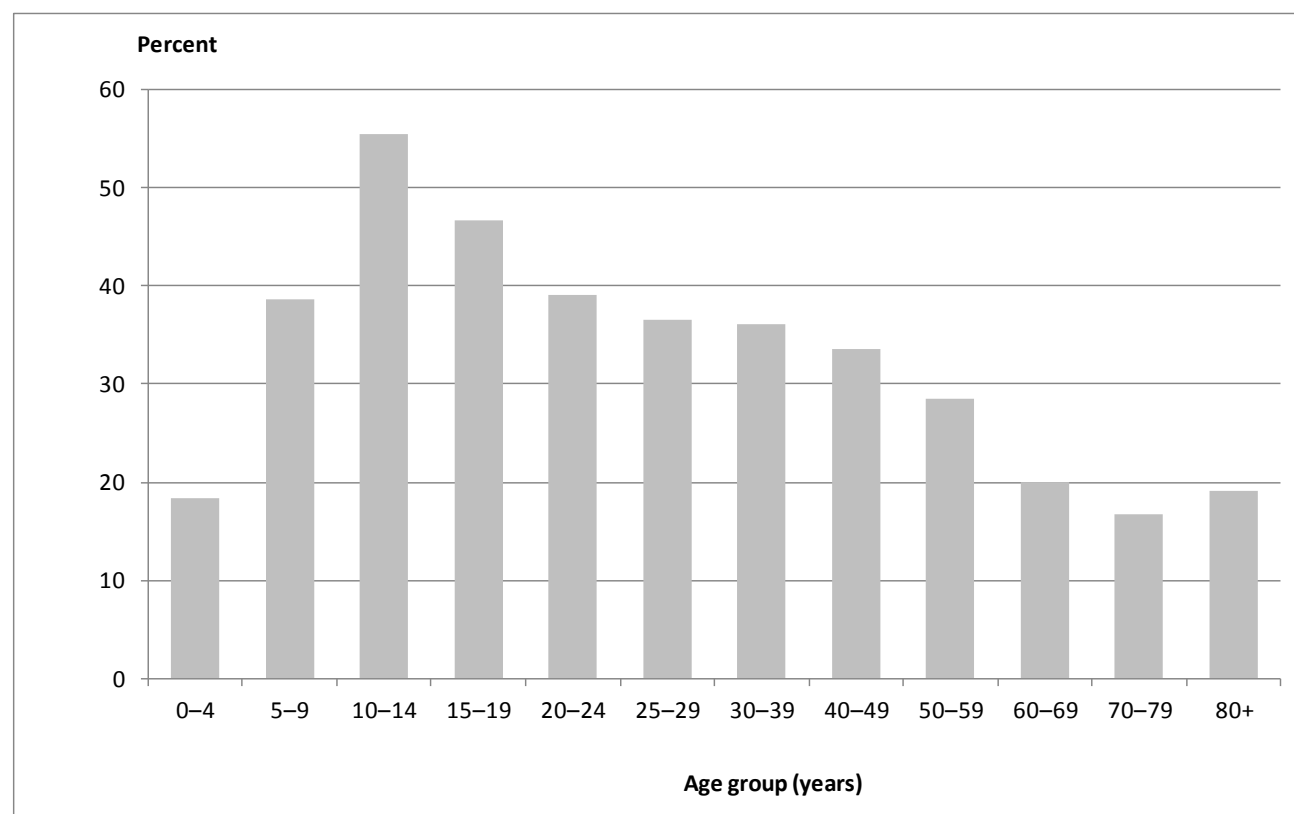
In 2010, New Plymouth District residents made a total of 25,080 emergency department visits. Of these, 7,666 (31%) were recorded as visits for injury treatment.

Looking at the balance of injury to non-injury visits by age, in the 10-14 year age group 55% of all emergency department visits were for injury. By contrast, just 17% of all emergency department visits by 70-79 year olds were for injury (see figure 5.1 below).

Figure 5.1**Emergency Department Attendances For Injury**

New Plymouth District, by age

2010



Source: Data supplied by Taranaki District Health Board. Data in appendix table 5.1.

Note: Year is calendar year 1 January to 31 December.

Information is for attendances at Taranaki District Health Board emergency departments at Taranaki Base and Hawera hospitals by people living in New Plymouth District. Excludes private accident and emergency clinics.

Age, gender and ethnicity

Looking at the 7,666 visits for injury, it is clear that they are often by children and young people. Forty-five percent, a total of 3,458 visits, were by children and young people aged 0–24 years. Thirty-nine percent or a total of 2,989 visits, were by people aged 25–59 years. Sixteen percent or 1,219 visits were by people aged 60+.

Fifty-eight percent or a total of 4,469 visits for injury were by males, with 42% or 3,197 visits by females (appendix table 5.2). Overall, males were more likely to visit local EDs for injury; they had an age-standardised rate of 13,640 visits per 100,000 population compared with a rate of 9,113 visits per 100,000 for females.

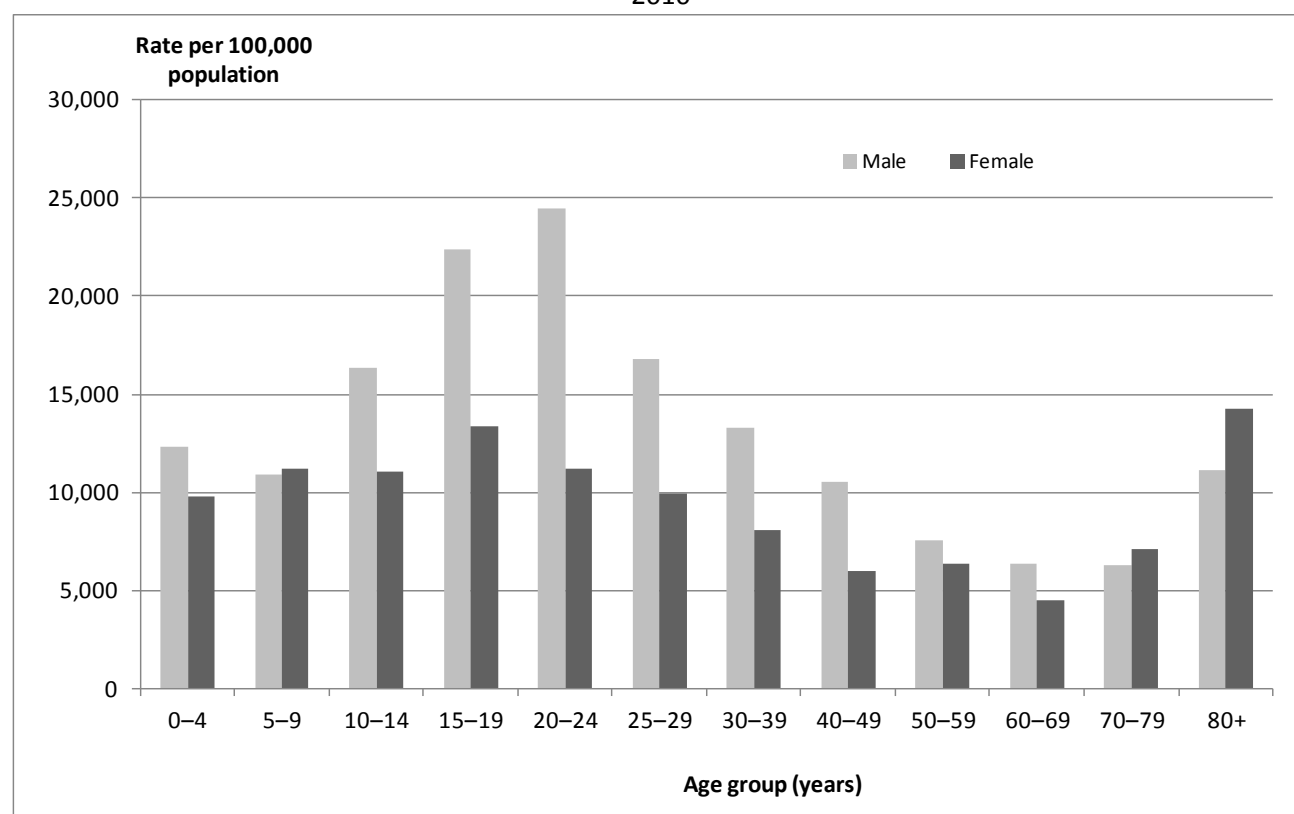
Comparing rates of emergency department visits by age and gender in more detail shows which groups in the New Plymouth District were most likely to make emergency department visits for injury in 2010 (figure 5.2).

Figure 5.2

Rate of Emergency Department Attendance for Injury

New Plymouth District, by age and gender

2010



Source: Data supplied by Taranaki District Health Board. Data in appendix table 5.3

Note: Year is calendar year 1 January to 31 December.

Information is for attendances at Taranaki District Health Board emergency departments at Taranaki Base and Hawera hospitals by people living in New Plymouth District. Excludes private accident and emergency clinics.

In all age groups except 70–79 and 80+, males were more likely than females to attend EDs for injuries. New Plymouth District males aged 20–24 were the most likely to visit an emergency department for injury (24,493 visits per 100,000 population) followed by males aged 15–19 (22,351 visits per 100,000 population).

Among females, those aged 80 or over were the most likely to visit an emergency department for injury (14,273 visits per 100,000 population) followed by 15–19 year olds (13,347 visits per 100,000 population).

Māori and non-Māori

Māori living in New Plymouth District made 1,276 emergency department visits for injury in 2010. This was 17% of all emergency department visits for injury. Non- Māori made 6,264 ED visits for injury (appendix table 5.4).²⁰

Almost two-thirds (65%) of injury visits by Māori were by males. This was a total of 832 visits by Māori males. Māori females made 444 injury visits.

For non- Māori, 57% of ED injury visits were for males and 43% were for females.

Fifty-nine percent of all emergency department visits for injury by New Plymouth District Māori were children and young people aged 0–24 years, a total of 750 visits.

Looking at population rates (figure 5.3 overleaf), Māori males aged 20–24 were the most likely to visit EDs for injury (31,594 visits per 100,000 population), followed by Māori males aged 80 or more (25,000 visits per 100,000 population).

Among Māori females, those aged 80 or more were the most likely to visit an emergency department for injury (19,444 visits per 100,000 population), followed by 20–24 year olds (16,817 visits per 100,000 population) and 25–29 year olds (13,084 visits per 100,000 population).

Overall, Māori males were more likely than Māori females to make an ED visit for injury in all age groups except 70–79.

Māori had higher age-standardised rates of ED visits for injury (13,442 per 100,000 population) than non- Māori (11,946 per 100,000).

Domicile Area Unit

The New Plymouth District domicile area unit (DAU) with the highest number of ED injury visits in 2010 was Struan Park (545 visits). Next was Bell Block (506 visits) followed by Moturoa (459 visits), Waitara West (437 visits) and Westown (424).

Analysing rates of ED injury visits by domicile area unit shows people in New Plymouth Central were by far the most likely to visit an ED for injury (49,254 visits per 100,000 population). Next were

²⁰ 126 people did not have their ethnic group recorded.

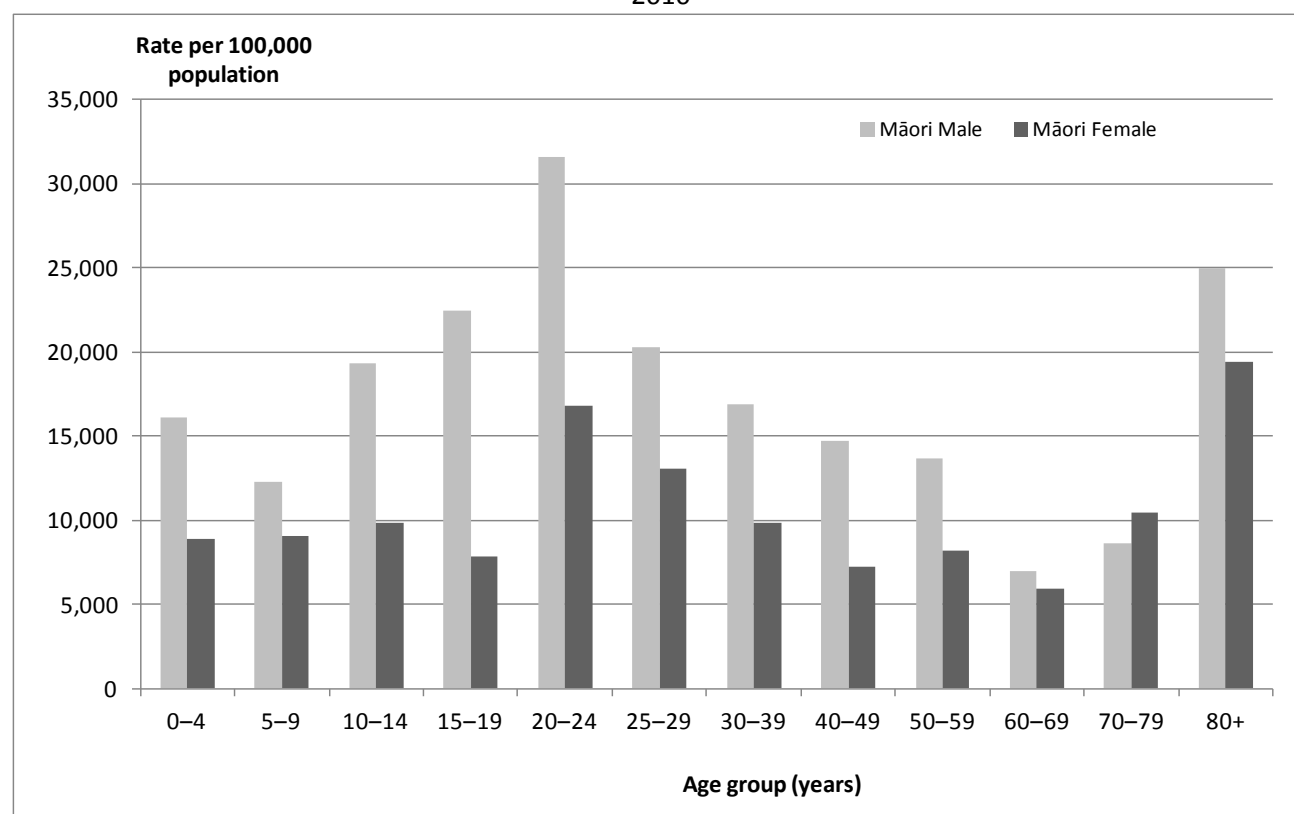
people in Marfell (15,164 visits per 100,000 population) followed by people in Urenui, Okato, Lynmouth, Kawaroa and Moturoa (between 12,000 and 13,500 visits per 100,000 population). However, note that these rates are not adjusted for age, so different age structures within these suburbs could account for some of the differences seen. For details see appendix table 5.6.

Figure 5.3

Māori Rate of Emergency Department Attendance for Injury

New Plymouth District, by age and gender

2010



Source: Data supplied by Taranaki District Health Board. Data in appendix table 5.5

Note: Year is calendar year 1 January to 31 December.

Information is for attendances at Taranaki District Health Board emergency departments at Taranaki Base and Hawera hospitals by people living in New Plymouth District. Excludes private accident and emergency clinics.

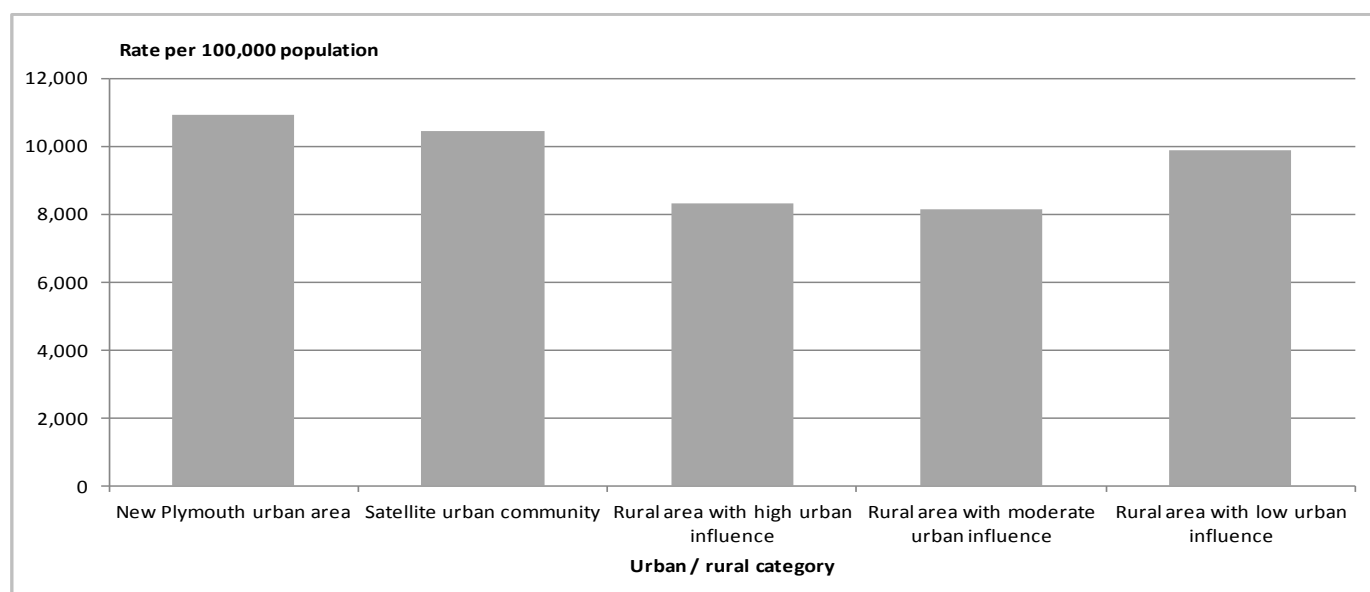
Urban / rural areas

As might be expected from the large number of people living in the New Plymouth urban area and nearby satellite urban areas such as Waitara and Inglewood, in 2010 the vast majority of ED attendances for injury were for these people (a total of 6,718 or 88% of injury attendances) (appendix table 5.7).²¹

People living in these urban areas also had the highest rates of ED attendances for injury. Rural areas with a low urban influence had the next highest rates; and rural areas with high and moderate urban influences had the lowest rates (figure 5.4). Note that people's level of geographic access to ED services as well as their true incidence of injury may have affected their rates of ED attendances for injury.

Figure 5.4

Emergency Department Attendance for Injury New Plymouth District, by urban / rural residence 2010



Source: Data supplied by Taranaki District Health Board. Data in appendix table 5.7

Note: Year is calendar year 1 January to 31 December.

Information is for attendances at Taranaki District Health Board emergency departments at Taranaki Base and Hawera hospitals by people living in New Plymouth District. Excludes private accident and emergency clinics.

²¹ See chapter 2 for a more detailed list of urban and rural areas within New Plymouth District.

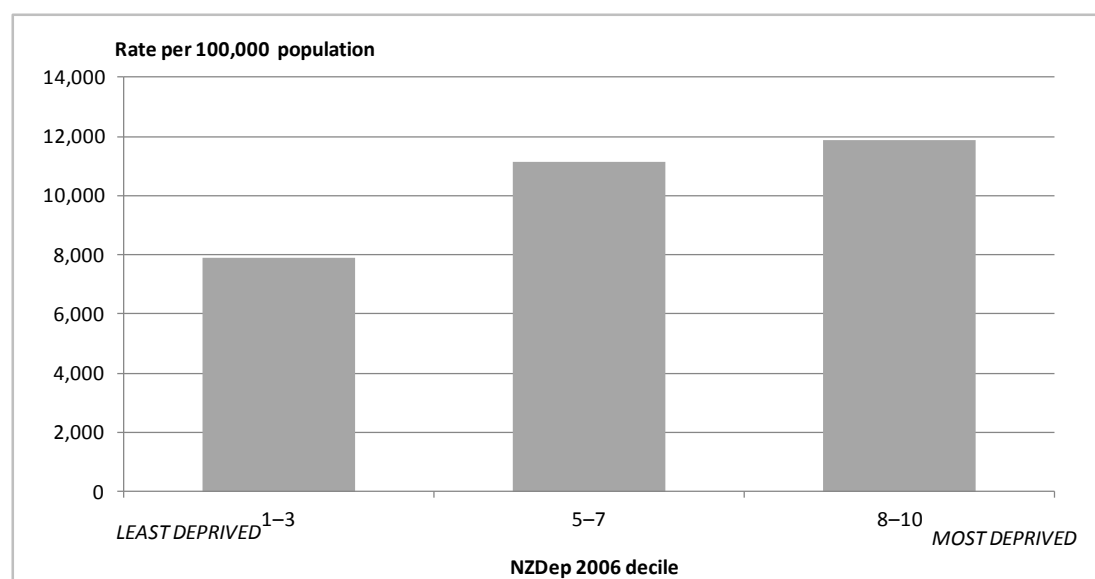
Neighbourhood deprivation (NZDep2006)

As already described in chapter 2, the New Zealand Deprivation Index (NZDep 2006) is a measure of the level of socioeconomic deprivation in small geographic areas (neighbourhoods) of New Zealand.

In 2010, people living in the least deprived areas had the lowest rates of ED attendance for injury, and people living in the most deprived areas had the highest rates (figure 5.5 overleaf).

Figure 5.5

Emergency Department Attendance for Injury New Plymouth District, by NZDep2006 deciles 2010



Source: Data supplied by Taranaki District Health Board. Data in appendix table 5.8

Note: Year is calendar year 1 January to 31 December.

Information is for attendances at Taranaki District Health Board emergency departments at Taranaki Base and Hawera hospitals by people living in New Plymouth District. Excludes private accident and emergency clinics.

Cause (mechanism) of injury

Approximately 58% of New Plymouth District emergency department visits for injury have been coded to a specific cause or 'mechanism' for the injury. The cause of the remaining 42% of visits has been coded as 'other'. It seems that a sizeable but unknown quantity of injury visits have been included in the 'other' cause category because no specific injury cause was identified or recorded at the time of the patient visit. As this cause data is only partially complete, it should therefore be treated as indicative only and used with caution.

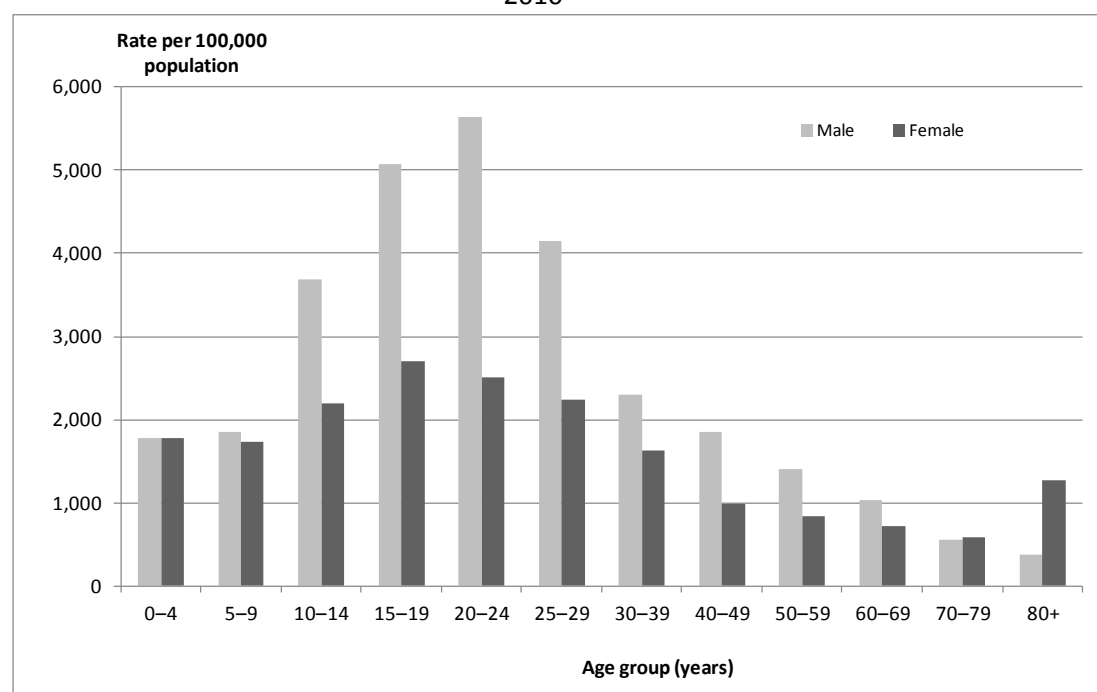
For New Plymouth District people, the most commonly recorded ED visit injury cause in 2010 was blunt trauma (1381 out of 7,666 injury visits - 18%). The age groups with the highest rates of blunt trauma cause were 20–24, followed by 15–19 and 25–29 (figure 5.6 below).

Figure 5.6

**Rate of Emergency Department Attendance
for Injury Caused by Blunt Trauma**

New Plymouth District, by age and gender

2010



Source: Data supplied by Taranaki District Health Board. Data in appendix table 5.5

Note: Year is calendar year 1 January to 31 December.

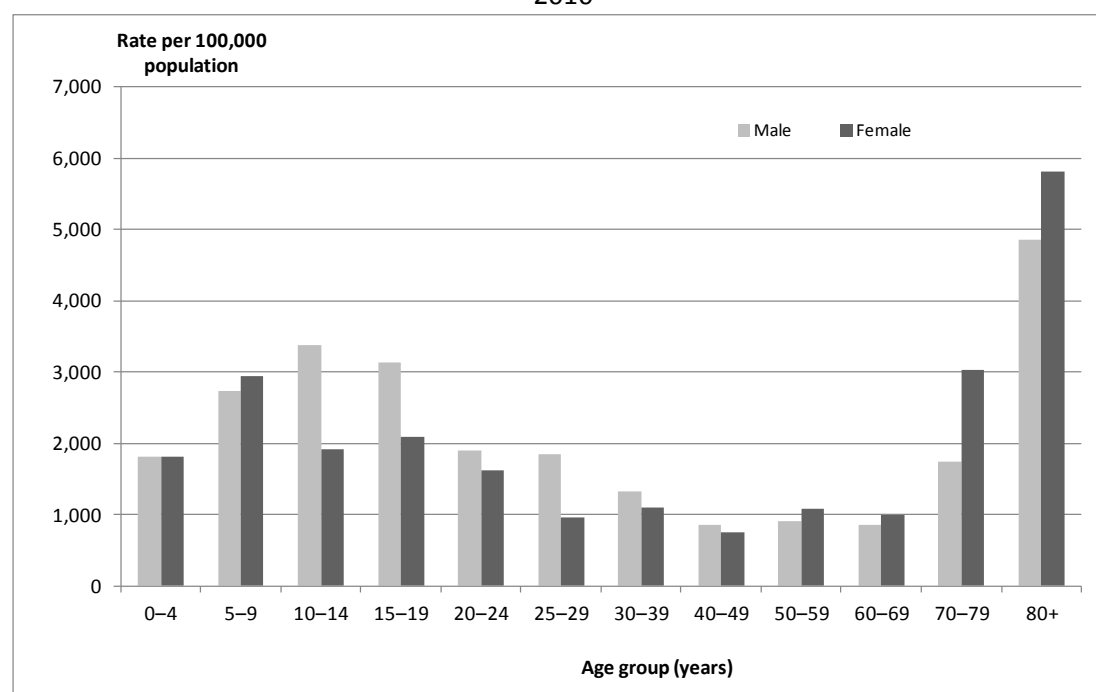
Information is for attendances at Taranaki District Health Board emergency departments at Taranaki Base and Hawera hospitals by people living in New Plymouth District. Excludes private accident and emergency clinics.

The second most commonly recorded ED visit injury cause was falls (1,296 out of 7,666 injury visits – 17%). Highest injury rates for falls were in the 80+ age group followed by the age groups 5–9, 10–14, 15–19 and 70–79 (figure 5.7).

Figure 5.7

Rate of Emergency Department Attendance for Injury Caused by Falls

New Plymouth District, by age and gender
2010



Source: Data supplied by Taranaki District Health Board. Data in appendix table 5.10

Note: Year is calendar year 1 January to 31 December.

Information is for attendances at Taranaki District Health Board emergency departments at Taranaki Base and Hawera hospitals by people living in New Plymouth District. Excludes private accident and emergency clinics.

Sizeable numbers of ED visits were also made for injuries recorded as caused by:

- penetrating trauma – 478 visits (6%), highest rates in age groups 20–24 and 25–29
- strain – 356 visits (5%), highest rates in age groups 20–24 and 15–19
- foreign body – 192 visits (3%), highest rates in age groups 0–4 and 5–9
- assault – 133 visits (2%), highest rates in age groups 20–24 and 15–19
- overdose – 111 visits (1%), highest rates in age groups 15–19 and 30–39.

Also note 'Other Mechanism' – 258 visits (3%), and 'Other Injury' – 3,187 visits (42%) (appendix table 5.9).²²

Location (scene) where injury occurred

Like the data on cause or 'mechanism' of injury (see above), the data on the location or 'scene' of ED injury visits must also be treated as indicative only and used with caution. This is because 42% of visits have not been ascribed to a specific place or location of injury (appendix table 5.11).

For New Plymouth District people, the most commonly recorded ED visit injury location / place was 'domestic' i.e. the home (2,328 out of 7,666 injury visits - 30%). The age groups with the highest rates of injury occurring at home were 80+, 0–4 and 20–24 (figure 5.8 overleaf).

The second most commonly recorded ED visit injury location / place was 'sports / recreation' (624 out of 7666 injury visits - 8%). 'Sports / recreation' ED visit rates were highest in age groups 15–19, 20–24 and 10–14 (figure 5.9 overleaf).

Notable numbers of ED visits were also made for injuries recorded as occurring in the following locations / places:

- 'public areas' – 491 visits (6%), highest rates in age groups 20–24, 15–19
- 'work' – 364 visits (5%), highest rates in age groups 20–24, 25–29
- 'school' – 196 visits (3%), highest rates in age groups 10–14, 5–9
- 'vehicle (automobile)' – 146 visits (2%), highest rates in age groups 20–24, 15–19 (appendix table 5.11).

²² Analysing only ED visits in 2010 where a specific injury cause is recorded provides the following percentages (for details see appendix table 5.11A):

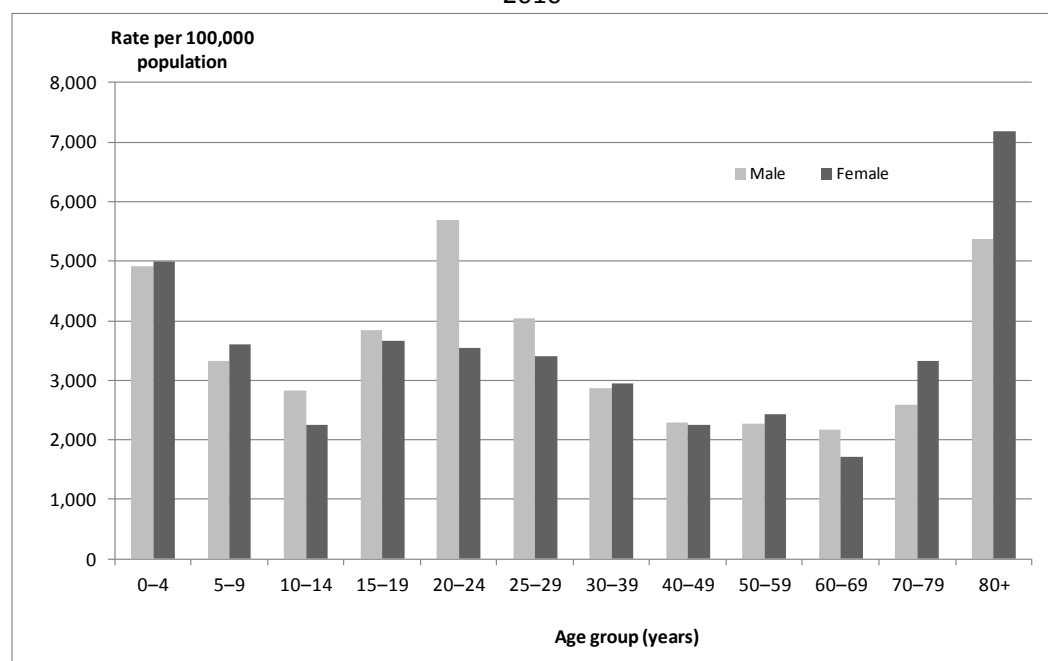
Blunt trauma	33 %
Fall	31 %
Penetrating trauma	11 %
Strain	8 %
Foreign body	5 %
Assault	3 %
Overdose	3 %
Bite	2 %
Allergic	2 %

Figure 5.8

Rate of Emergency Department Attendance for Injury at Home ('Domestic')

New Plymouth District, by age and gender

2010



Source: Data supplied by Taranaki District Health Board. Data in appendix table 5.12.

Note: Year is calendar year 1 January to 31 December.

Information is for attendances at Taranaki District Health Board emergency departments at Taranaki Base and Hawera hospitals by people living in New Plymouth District. Excludes private accident and emergency clinics.

Trends in emergency department visits

This section compares New Plymouth District ED injury data across the years: 2001, 2005 and 2010.²³

Over this time the total number of emergency department injury visits increased (although as a proportion of all ED visits they decreased) as follows:

- 2000 – 6,531 visits for injury = 36% of all ED visits
- 2005 – 7,249 visits for injury = 35% of all ED visits
- 2010 – 7,666 visits for injury = 31% of all ED visits.²⁴

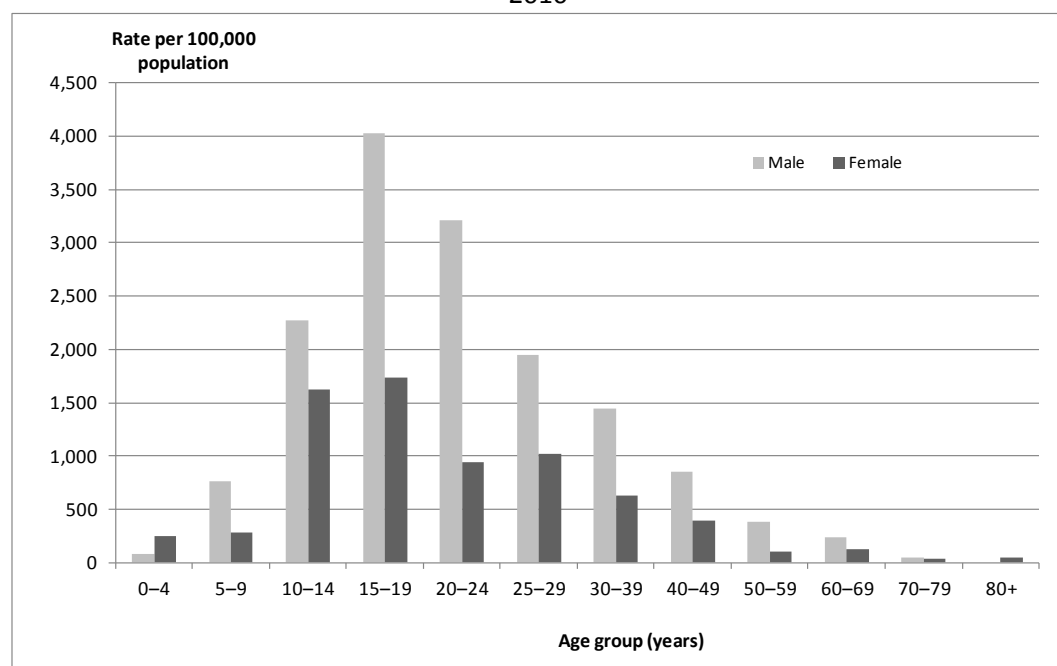
²³ 2001 and 2006 were the two previous years when needs assessments were conducted in the district. Data for 2000 is reported in the 2001 needs assessment (McClellan et al 2001); and data for 2005 is reported in the 2006 needs assessment (McClellan et al 2006).

Figure 5.9

Rate of Emergency Department Attendance for Injury at Sport / Recreation Venues

New Plymouth District, by age and gender

2010



Source: Data supplied by Taranaki District Health Board. Data in appendix table 5.12.

Note: Year is calendar year 1 January to 31 December.

Information is for attendances at Taranaki District Health Board emergency departments at Taranaki Base and Hawera hospitals by people living in New Plymouth District. Excludes private accident and emergency clinics.

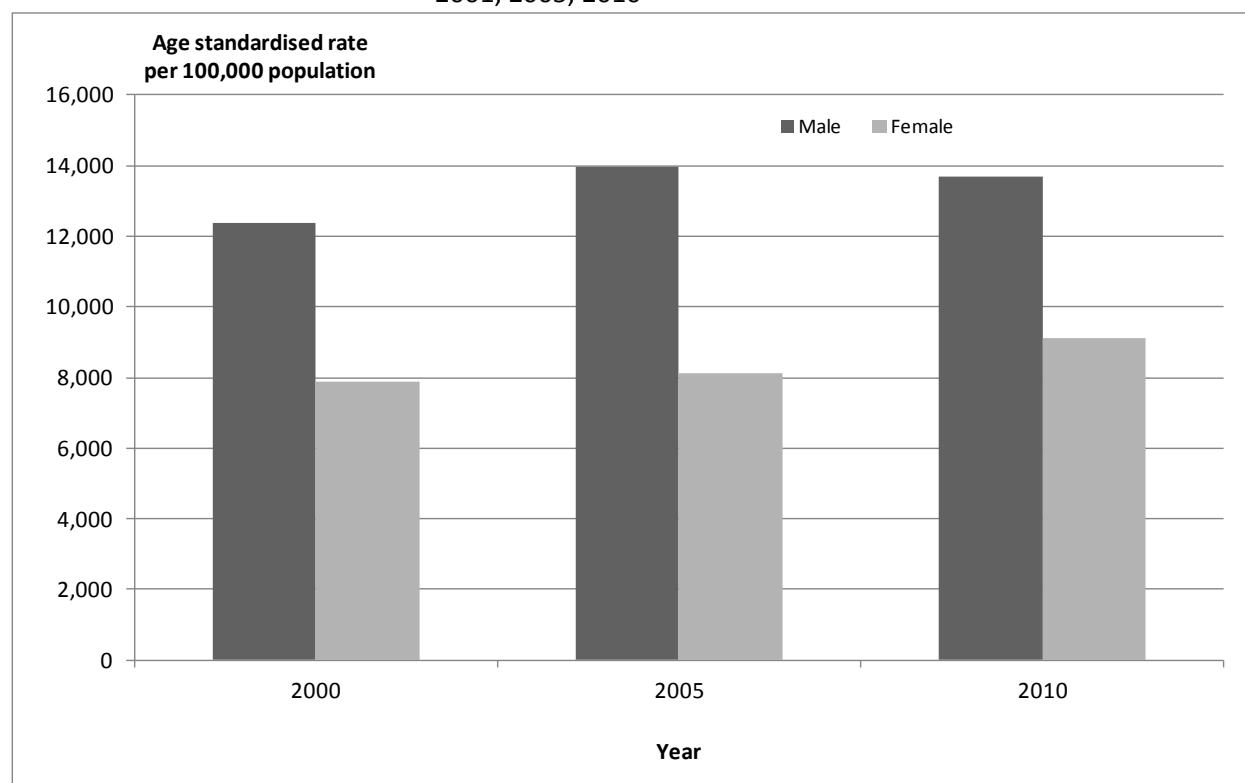
Age-standardised rates of ED injury attendances were higher in 2005 (11,567 per 100,000 population) than in 2000 (10,136 per 100,000). However, 2010's rate (11,434 per 100,000) was slightly lower than 2005's (appendix table 5.14).

Rates for males followed the pattern of being lowest in 2000, highest in 2005 and inbetween in 2010. However, rates for females increased steadily across these three years (figure 5.10 overleaf).

²⁴ See appendix table 5.13 for more detail.

Figure 5.10

Rate of Emergency Department Attendance for Injury
 New Plymouth District, by gender
 2001, 2005, 2010



Source: Data supplied by Taranaki District Health Board. Data in appendix table 5.14.

Note: Year is calendar year 1 January to 31 December.

Information is for attendances at Taranaki District Health Board emergency departments at Taranaki Base and Hawera hospitals by people living in New Plymouth District. Excludes private accident and emergency clinics.

For the same three years, appendix table 5.15 shows the number and percentage of ED visits for injury causes / mechanisms. There were much larger percentages of undefined causes in 2005 (38%) and 2010 (45%) compared with 2000 (7%). However, analysing data where cause had been defined, there was an increase in the proportion of ED injury visits due to blunt trauma (23% in 2000, 32% in 2005, 33% in 2010) and a decrease in falls (38% in 2000, 34% in 2005, 31% in 2010).

6

ACC INJURY CLAIMS

This chapter examines Accident Compensation Corporation (ACC) injury claims data for New Plymouth District. The data analysed here is for 'new entitlement claims' which relate to medical expenses, rehabilitation costs and compensation for lost income.

It is important to remember that this new entitlement claims data is collected largely for administrative purposes. It does not capture all injury events in the community. Obviously it excludes injury cases where no ACC claim is made, as well as cases where a claim is made but not accepted. It also excludes 'minor' claims for primary health care (which make up over 90 percent of all new claims registered²⁵), dental-only claims and ongoing claims.

Despite these limitations, ACC claims data do provide a useful indication of broader injury patterns in the New Plymouth District, particularly when examined alongside the emergency department and hospitalisation statistics presented earlier.

The data covers claims for injuries occurring in the New Plymouth District regardless of whether the claimant was a resident of the district at the time of the injury or not (personal communication, ACC). For the purposes of this report, however, it has been assumed that the vast majority of claims were by New Plymouth District residents, with population rates calculated on this basis.

The main period examined here is the 2010/11 financial year (1 July 2010 to 30 June 2011). This is the latest full year for which new entitlement claims data is available. Some data is also provided for the five year period 2006/07–2010/11 and occasionally claims data is traced back to 2000/01.

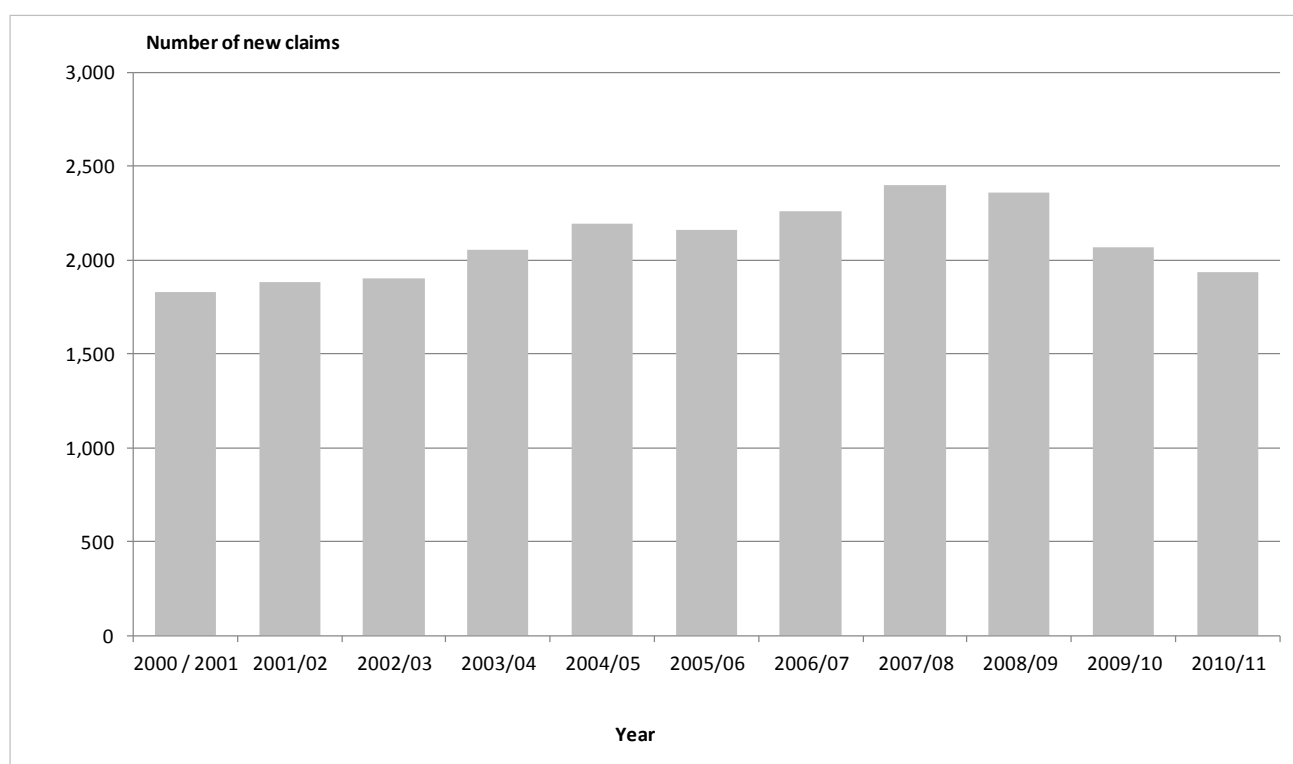
²⁵ In the year to 30 June 2011, 1,675,107 new claims were registered nationally, of which 97,759 (6%) were new entitlement claims (Accident Compensation Corporation 2011).

Trends in claims

In the eight financial years from 2000/01 to 2007/08, the number of accepted ACC new entitlement claims for New Plymouth District steadily increased (figure 6.1). However, the two most recent financial years saw a clear drop in the number of accepted new claims to 2,068 in 2009/10 and 1,935 in 2010/11.

Figure 6.1

ACC New Entitlement Claims for All Types of Injury New Plymouth District 2000/01–2010/11



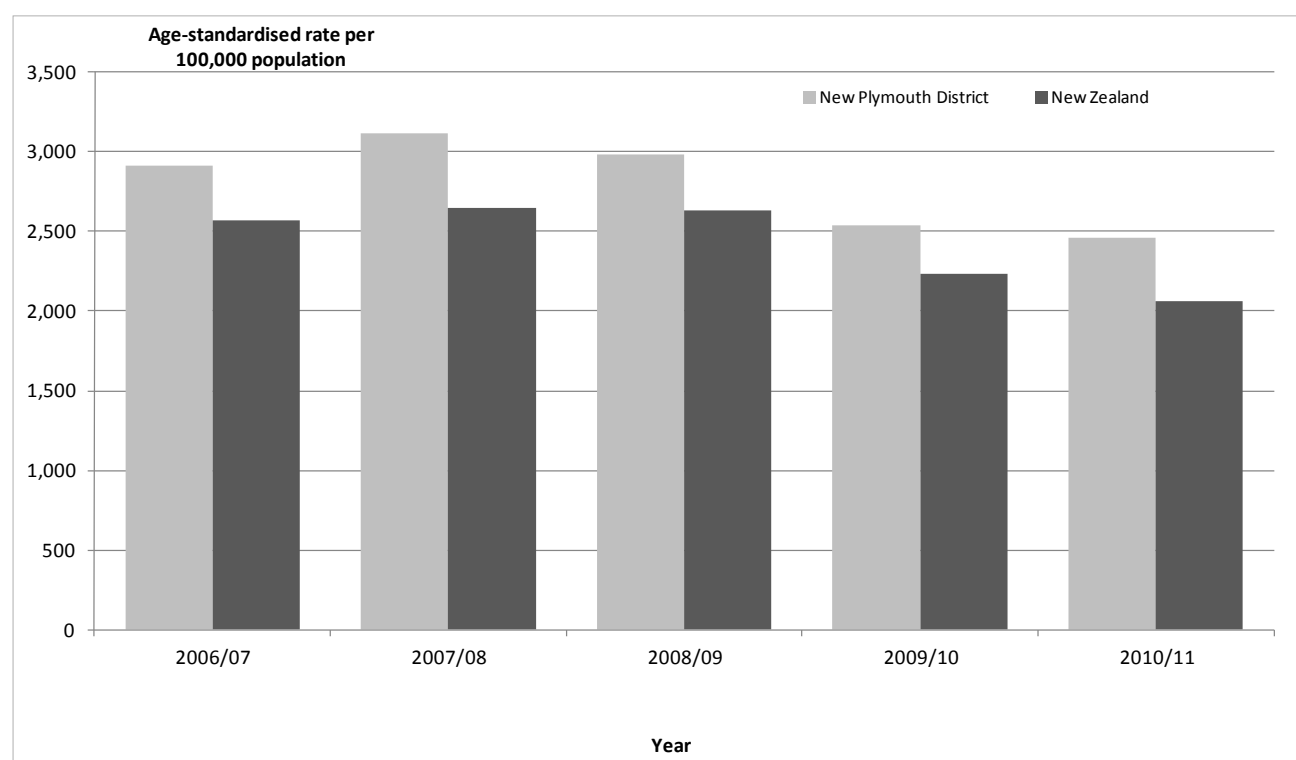
Source: Data supplied by Accident Compensation Corporation. Data in appendix table 6.1.

Note: Years are financial years 1 July to 31 June.
Information is for *accepted* new entitlement claims.

In the five most recent financial years to 2010/11, New Plymouth District's rate of accepted new entitlement claims was consistently higher than the overall New Zealand rate (figure 6.2). Rates for both New Plymouth and New Zealand have been decreasing since 2007/8.

Figure 6.2

ACC New Entitlement Claims for All Types of Injury
New Plymouth District and New Zealand
2006/07–2010/11



Source: Data supplied by Accident Compensation Corporation. Data in appendix table 6.2.

Note: Years are financial years 1 July to 31 June.

Information is for *accepted* new entitlement claims.

Rates calculated using Statistics New Zealand estimated population for each year (i.e. estimated population for 2005 used for 2004/05, etc.), except New Plymouth District estimated population for 2010 used for the 2010/11 financial year.

Age-standardised rates (ASRs) calculated using Segi world standard population.

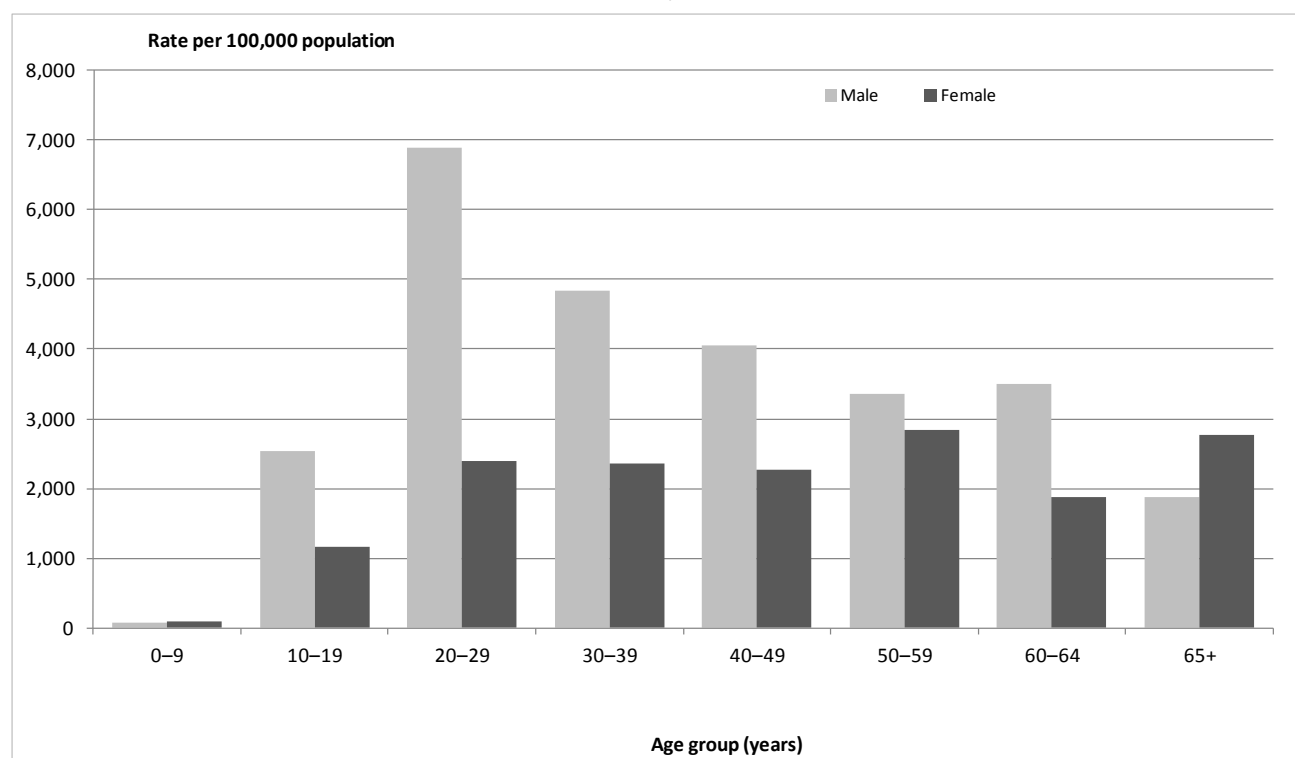
Age and sex of claimants

In 2010/11, there was an annual total of 1,926 new entitlement claims for New Plymouth District; 1,170 (61%) for males and 756 (39%) for females. The over-representation of males here is not surprising and is consistent with injury data from other services such as hospital emergency departments and inpatient facilities. In 2010/11, claim rates for males in New Plymouth District were nearly double those for females (3,219 per 100,000 population compared with 1,693 per 100,000).

New Plymouth District males aged 20–29 had the highest rate of accepted new claims, followed by males aged 30–39 and 40–49 (figure 6.3). For New Plymouth District females, the highest rates of accepted new claims were in the 50–59 and 65+ age groups. This supports the common observation in previous chapters that younger adult males and older adult females have higher injury rates than the rest of their gender group.

Figure 6.3

ACC New Entitlement Claims for All Types of Injury New Plymouth District, by age and gender 2010/11



Source: Data supplied by Accident Compensation Corporation. Data in appendix table 6.3.

Note: Years are financial years 1 July to 31 June.
Information is for *accepted* new entitlement claims.
Rates calculated using Statistics New Zealand estimated population for 2010 for New Plymouth District.

Ethnicity

In 2010/11, of the 1,930 new entitlement claims for accident injury in New Plymouth District, 1,627 or 84% were for European / Pakeha people. Eleven percent were for Māori people and 4% were for people of other ethnicities (for details see appendix table 6.4).

Comparing age-standardised claim rates per 100,000 population in 2010/11, the rate for New Plymouth District Māori was slightly lower than for non-Māori (2,292 per 100,000 vs. 2,742 per 100,000). Nationally, new claim rates for Māori were also lower than for non-Māori (2,033 per 100,000 vs. 2,352 per 100,000) (appendix table 6.5).

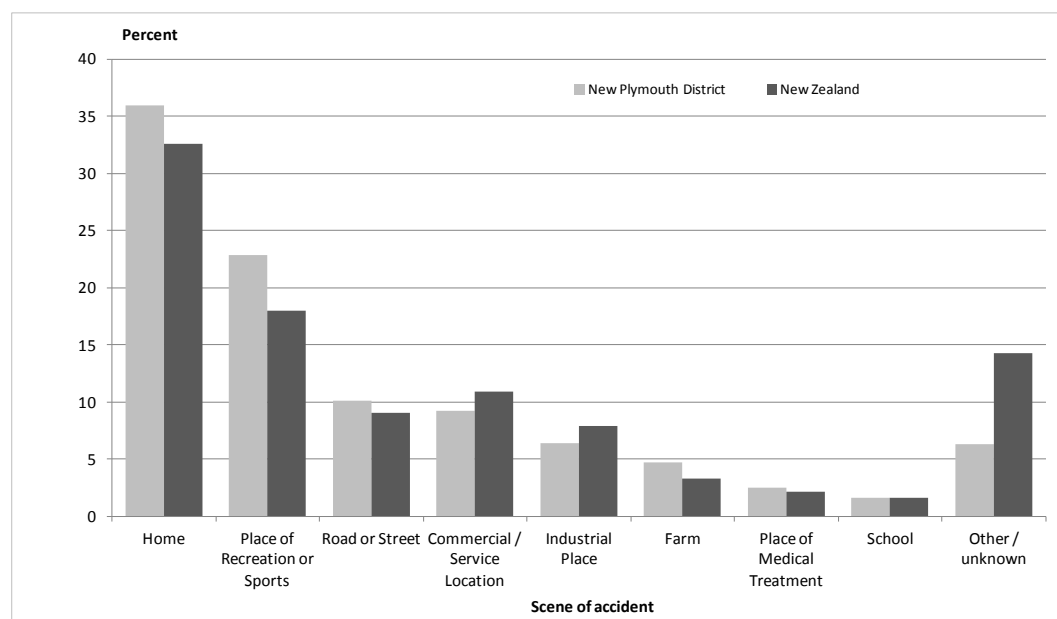
Location (scene) of accident

In New Plymouth District in 2010/11, the home was the most common place where injuries occurred resulting in ACC new entitlement claims (36% of all claims). Next were sport and recreation venues (23% of all claims).

Compared to New Zealand as a whole, New Plymouth District had a higher proportion of injuries sustained either at home, places of recreation or sports, on roads or streets, or on farms. Lower proportions were sustained locally in commercial / service locations and industrial places (figure 6.4).

Figure 6.4

ACC New Entitlement Claims for All Types of Injury
New Plymouth District and New Zealand, by scene of accident
2010/11



Source: Data supplied by Accident Compensation Corporation. Data in appendix table 6.6.

Note: Year is financial year 1 July to 31 June.
Information is for *accepted* new entitlement claims.

In New Plymouth District, compared to males, females had a higher proportion of their injuries sustained at home, places of medical treatment and schools. Indeed, almost half (49%) of all female new entitlement claims were for injuries sustained in the home (figure 6.5).

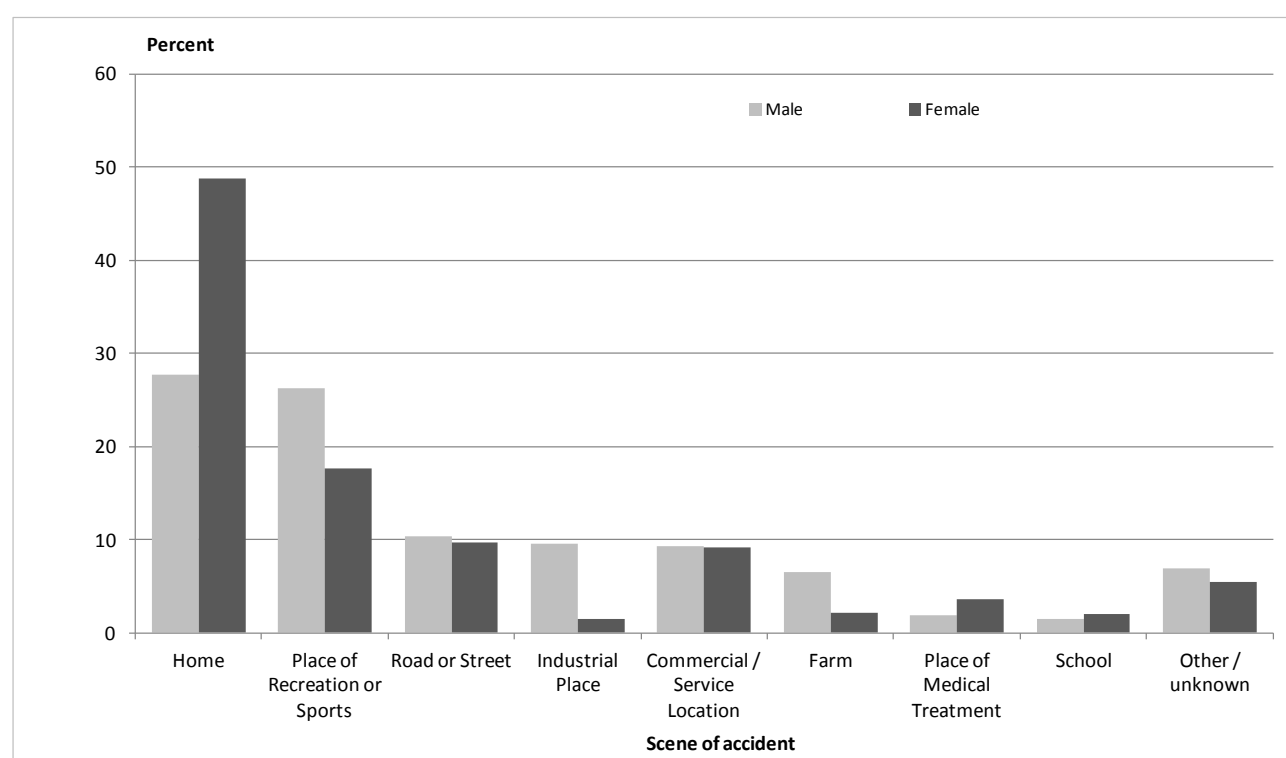
Males, by contrast, sustained a higher proportion of their injuries at recreation or sports places, industrial places, and farms. These differences doubtless partly reflect general male and female differences in work, occupation and recreational choices.

Figure 6.5

ACC New Entitlement Claims for All Types of Injury

New Plymouth District, by scene of accident and gender

2010/11



Source: Data supplied by Accident Compensation Corporation. Data in appendix table 6.7.

Note: Year is financial year 1 July to 31 June.
Information is for *accepted* new entitlement claims.

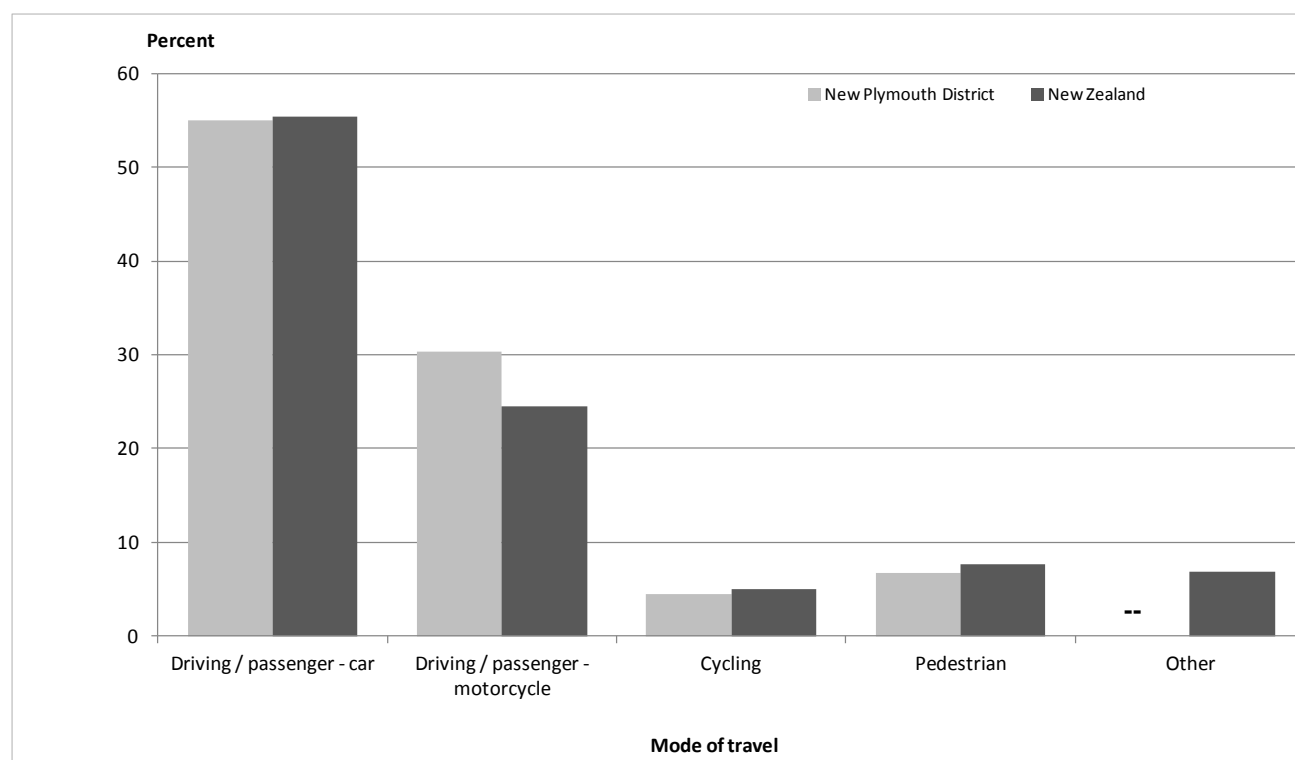
Road accident injuries

For New Plymouth District, in the five financial years to 2010/11, there were a total of 507 ACC new entitlement claims for road accident (crash) injuries – an average of 101 new road injury claims a year (see appendix table 6.8).

In 2010/11, road accident injury claims made up 5% (89 of 1,930) of all new entitlement claims for New Plymouth District. This was similar to the proportion for New Zealand as a whole (4% - 4,334 of 101,923).

Figure 6.6

ACC New Entitlement Claims for Road Accident Injuries New Plymouth District and New Zealand, by mode of travel 2010/11



Source: Data supplied by Accident Compensation Corporation. Data in appendix table 6.8.

Note: Year is financial year 1 July to 31 June.

Information is for *accepted* new entitlement claims.

-- percentage cannot be calculated. 'Other' includes driver / passenger of bus, truck, ATV and other vehicles.

The most common crash injury claims were for injuries to drivers or passengers of cars (New Plymouth District 55%), followed by injuries to drivers or passengers of motorcycles (New Plymouth District 30%) (figure 6.6). Compared to New Zealand as a whole, New Plymouth District had a greater proportion of road injury claims by drivers or passengers of motorcycles, but slightly smaller proportions of road injury claims by cyclists and pedestrians.

Sports / recreation injuries

In 2010/11 there were 476 New Plymouth District ACC new entitlement claims for sports / recreation injuries. This was 25% of all New Plymouth District new claims that year. By comparison, sports / recreation injuries made up 21% of all new claims for New Zealand as a whole.

In the four previous financial years from 2006/07 to 2009/10, sports / recreation injuries made up between 20 and 22% of all New Plymouth District new claims. For New Zealand as a whole the proportions ranged from 17 to 20%.

In 2010/11 in New Plymouth District the most common type of sport / recreation for which ACC new entitlement claims were made was rugby union. Altogether, 96 or 20% of New Plymouth District sport / recreation injury claims were for rugby union. This compares to 16% for New Zealand as a whole (figure 6.7 overleaf).

The next highest sport / recreation injury claim group in New Plymouth District was netball (9%), followed by rugby league (7%), cycling (7%) and soccer (6%).

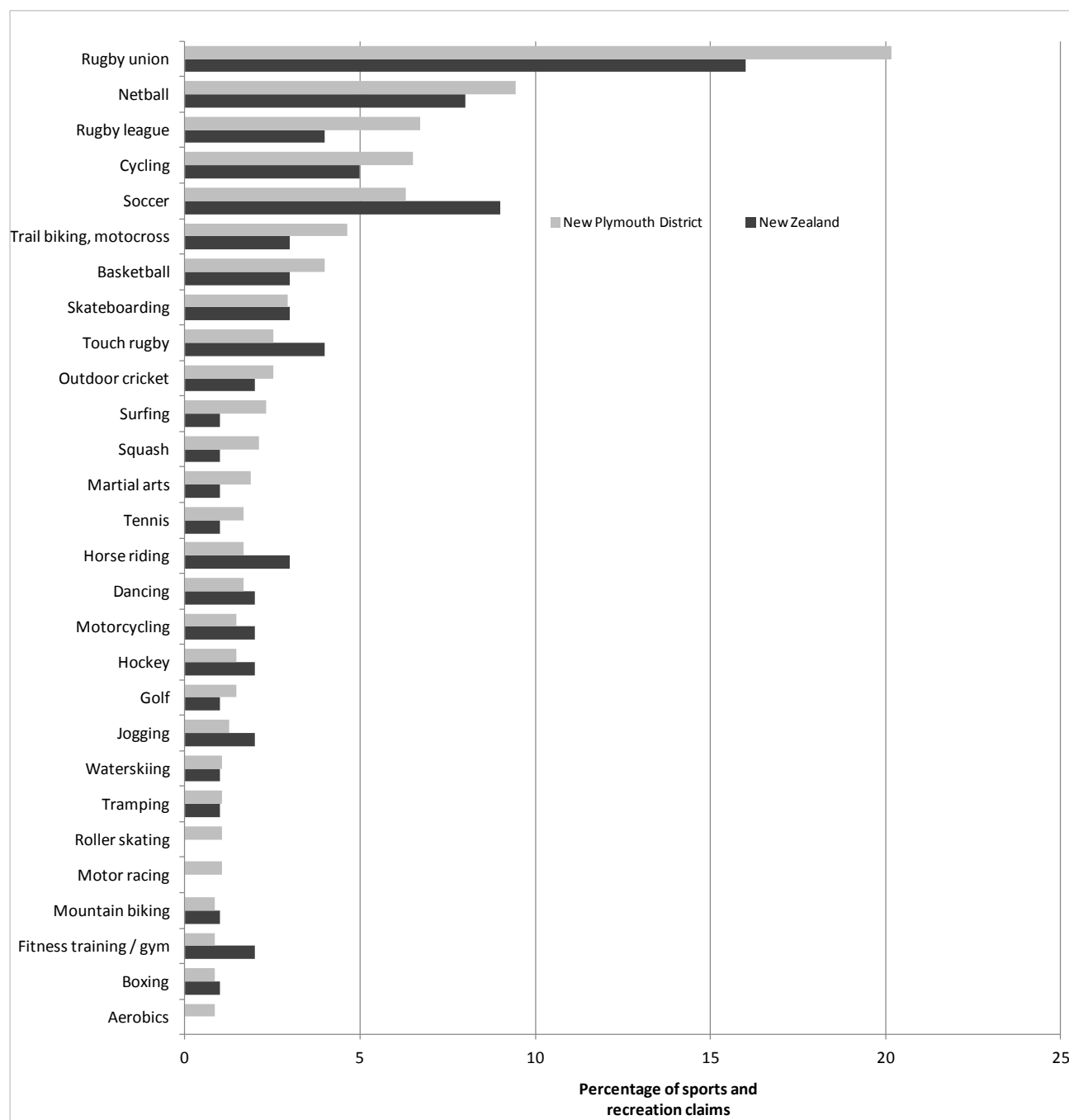
Compared to New Zealand as a whole, New Plymouth District's sport / recreation injury claims included higher proportions of netballers, rugby league players, cyclists, trail or motocross bike riders, and basketballers. However, there were lower proportions of soccer players and touch rugby players.

Figure 6.7

Sports and Recreation with Highest ACC New Entitlement Claims for Injury

New Plymouth District and New Zealand

2010/11



Source: Data supplied by Accident Compensation Corporation. Data in appendix tables 6.11 and 6.12.

Note: Year is financial year 1 July to 31 June.

Information is for *accepted* new entitlement claims.

Excludes sports and recreation types with less than one percent of New Plymouth District new entitlement claims in 2010/11.

Workplace injuries

In 2010/11, a total of 447 or 23% of New Plymouth District new ACC claims were work-related. This compares to 28% in New Zealand as a whole.

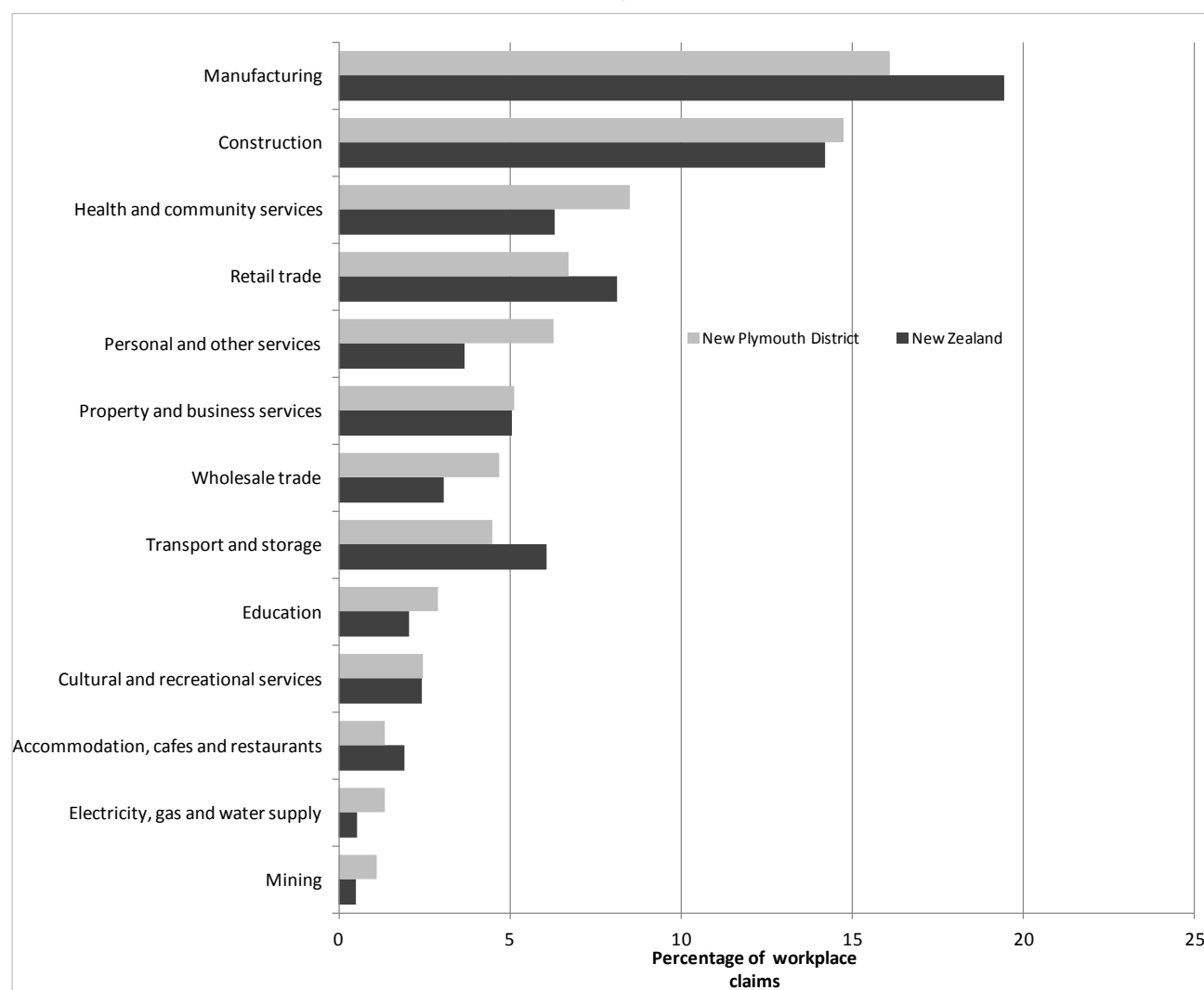
In New Plymouth District, the largest proportion of work-related claims came from the manufacturing sector (16%). Next was construction (15%), health and community services (9%) and retail (7%) (appendix 6.13).

Compared to New Zealand as a whole, New Plymouth District had higher proportions of work-related claims from construction, health and community services, personal and other services, and the wholesale trade (plus other sectors, for details see figure 6.8 overleaf). However, the proportion of claims from manufacturing and retail were lower in New Plymouth District than New Zealand as a whole. This is at least partly because of the different industry profile of New Plymouth District compared with New Zealand as a whole.

In the two latest financial years, 2009/10 and 2010/11, total new claims from the New Plymouth District manufacturing sector were markedly lower than in the previous three years (see figure 6.9 overleaf). Construction; agriculture, forestry and fishing; retail; and property and business services also recorded noteworthy drops in annual numbers of new claims.

Figure 6.8

**Industries with Highest Number of ACC New Entitlement Claims
for Workplace Injury**
New Plymouth District and New Zealand
2010/11

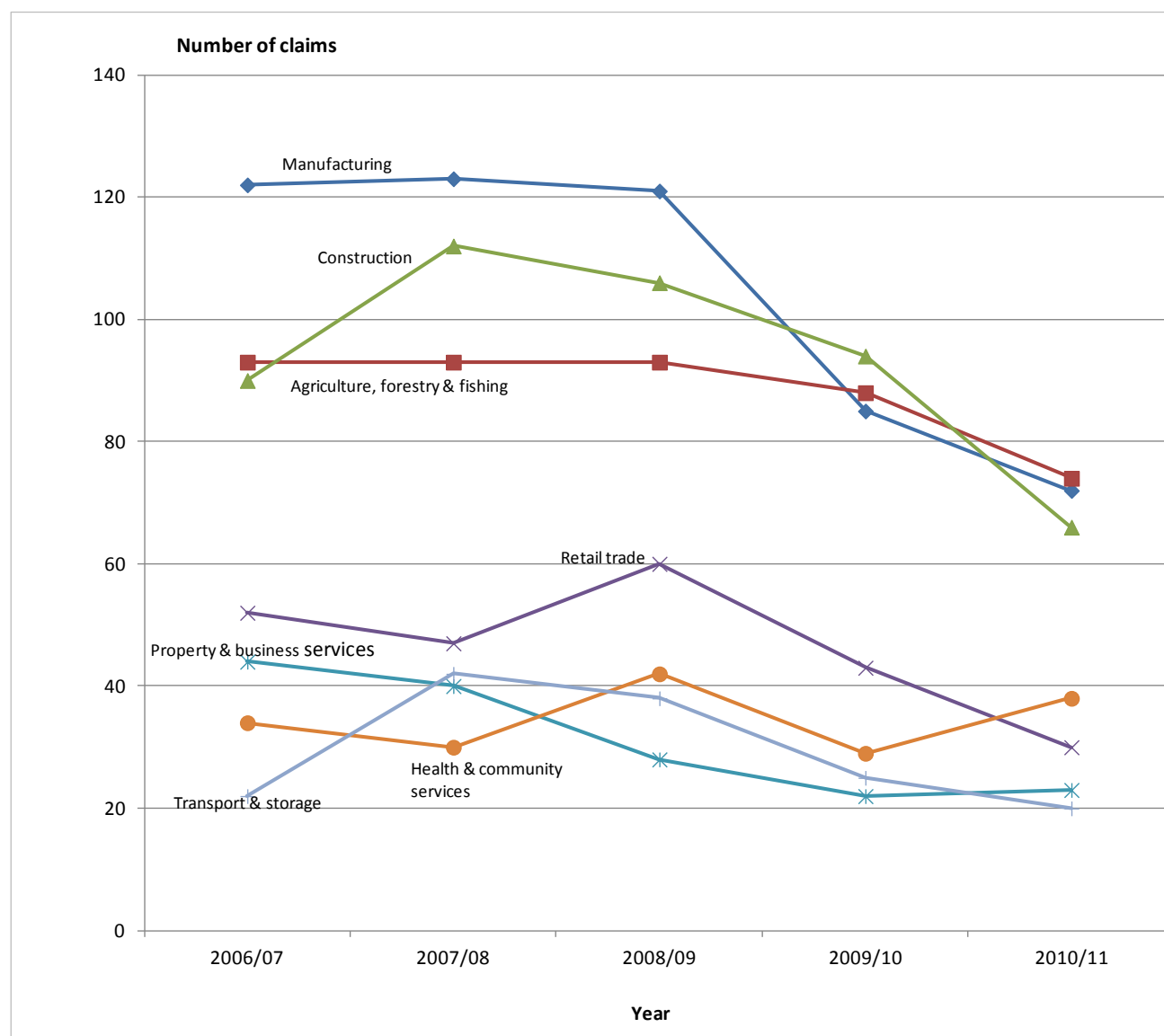


Source: Data supplied by Accident Compensation Corporation. Data in appendix table 6.13.

Note: Year is financial year 1 July to 31 June.
Information is for *accepted* new entitlement claims.
Excludes industries with one percent or less of New Plymouth District new entitlement claims in 2010/11.

Figure 6.9

Trends in Workplace Injury ACC New Entitlement Claims
New Plymouth District
2006/07–2010/11



Source: Data supplied by Accident Compensation Corporation. Data in appendix table 6.11.

Note: Years are financial years 1 July to 31 June.
Information is for *accepted* new entitlement claims.
Excludes industries with less than four percent of New Plymouth District new entitlement claims in 2006/07.

Injury diagnoses

A total of 898 or nearly half (47%) of all new entitlement claims in New Plymouth District were for soft tissue injuries (contusions, internal organ injuries or strains). Another 660 (34%) were for fractures or dislocations, meaning these two types of injuries accounted for 8 out of every 10 local claims. This was similar to the national picture where 48% of claims were for soft tissue injuries and 31% were for fractures or dislocations (appendix table 6.14).

Table 6.1 lists the most common types of injury for which new ACC claims were accepted in New Plymouth District in 2010/11, sub-divided by the 'scene' or location where the injury occurred.

Soft tissue injury was the commonest injury type (diagnosis) for accidents occurring in the home, recreation or sports places, commercial and service locations, industrial places, farms and schools. In particular, 60% of the accidents occurring in recreation or sports places, 56% of the accidents occurring in schools and 50% of the accidents occurring in commercial and service locations involved some type of soft tissue injury (e.g. contusion, strain, etc).

In general, fracture / dislocation was the second most common injury type after soft tissue injury. For example, 36% of accidents occurring in the home involved some kind of fracture / dislocation, as did 36% of accidents occurring at recreation or sports places. However, for accidents occurring on roads or streets, fracture / dislocation was the commonest injury type, making up 54% of new entitlement claims for road accidents.

Note that deafness is the second most common injury type recorded for claims made for injuries sustained in industrial places, and the third most common for injuries on farms. Altogether, 23% of all claims made for injuries sustained in industrial places involved deafness, as did 15% of all claims for injuries on farms.

Table 6.1

**Scene of Accident and Most Common* Medical Diagnoses –
ACC New Entitlement Claims for All Types of Injury**

New Plymouth District

2010/11

Scene: Home			Scene: Place of Recreation or Sports		
Commonest diagnoses	No. of claims	Percent	Commonest diagnoses	No. of claims	Percent
Soft tissue injury (contusion, internal organ, strain)	305	44	Soft tissue injury (contusion, internal organ, strain)	264	60
Fracture / dislocation	249	36	Fracture / dislocation	157	36
Infected / non-infected laceration, puncture wound, sting	56	8			
Hernia	20	3			

Scene: Commercial / Service Location			Scene: Road or Street		
Commonest diagnoses	No. of claims	Percent	Commonest diagnoses	No. of claims	Percent
Soft tissue injury (contusion, internal organ, strain)	90	50	Fracture / dislocation	106	54
Fracture / dislocation	41	23	Soft tissue injury (contusion, internal organ, strain)	61	31
Infected / non-infected laceration, puncture wound, sting	13	7	Infected / non-infected laceration, puncture wound, sting	14	7
Deafness	11	6	Concussion / brain injury	6	3
Gradual onset (not disease / infection)	8	4			

Scene: Industrial Place			Scene: Farm		
Commonest diagnoses	No. of claims	Percent	Commonest diagnoses	No. of claims	Percent
Soft tissue injury (contusion, internal organ, strain)	51	41	Soft tissue injury (contusion, internal organ, strain)	34	37
Deafness	28	23	Fracture / dislocation	33	36
Infected / non-infected laceration, puncture wound, sting	14	11	Deafness	14	15
Fracture / dislocation	12	10	Infected / non-infected laceration, puncture wound, sting	6	7
Gradual onset (not disease / infection)	5	4			
Hernia	5	4			

Scene: Place of Medical Treatment			Scene: School		
Commonest diagnoses	No. of claims	Percent	Commonest diagnoses	No. of claims	Percent
Other	16	33	Soft tissue injury (contusion, internal organ, strain)	18	56
Soft tissue injury (contusion, internal organ, strain)	13	27	Fracture / dislocation	12	38
Fracture / dislocation	12	24			

Source: Data supplied by Accident Compensation Corporation. Data in appendix table 6.15.

Note: Years are financial years 1 July to 31 June.
Information is for *accepted* new entitlement claims.

*Excludes diagnoses with less than three percent of claims for an accident scene.

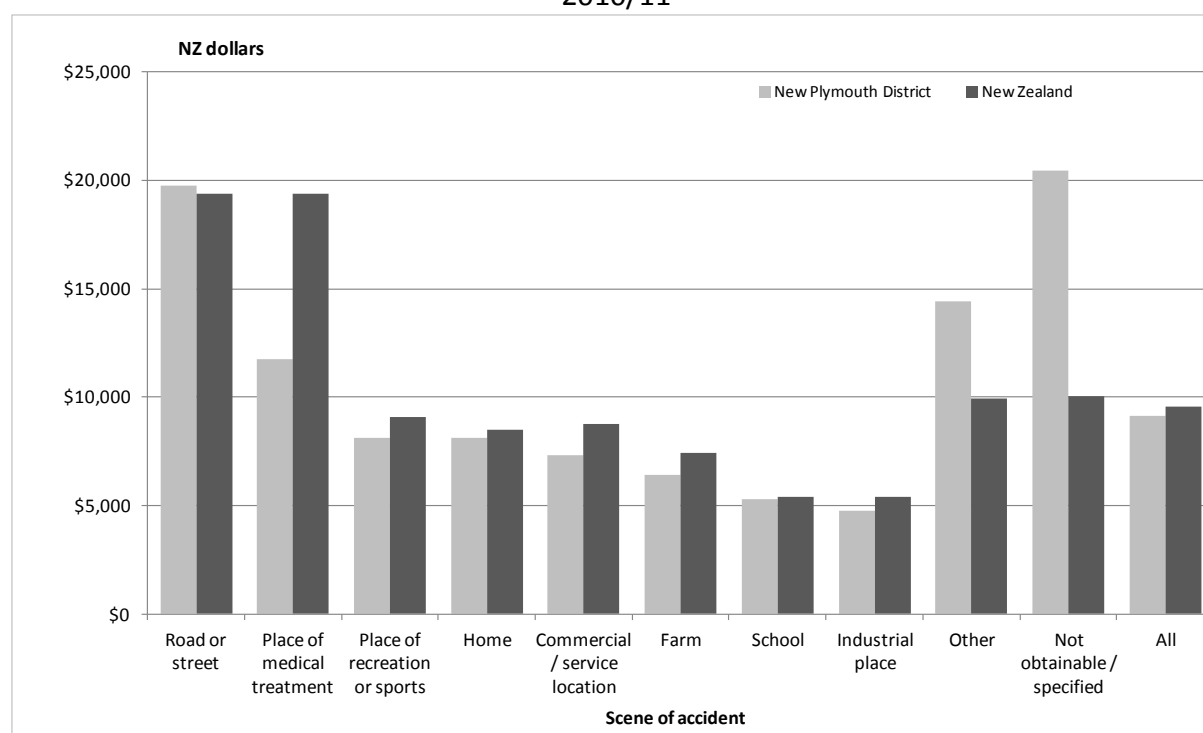
Cost of claims

Figure 6.10 shows the average cost per *active* ACC entitlement claim in 2010/11 for New Plymouth District and New Zealand, sub-divided by the scene or place the accident occurred resulting in the claim. Active claims are the sum of all new and existing ACC entitlement claims in any given time period.

Overall, the average cost of all active New Plymouth District ACC claims in 2010/11 was \$9,117. This was slightly lower than the average cost for New Zealand as a whole, which was \$9,540.

Figure 6.10

Average Annual ACC Expenditure Per Active* Entitlement Claim
New Plymouth District and New Zealand, by scene of accident
2010/11



Source: Data supplied by Accident Compensation Corporation. Data in appendix table 6.16.

Note: Year is financial year 1 July to 31 June.

*active entitlement claims = new + existing entitlement claims.

The most costly injury accidents in New Plymouth District (and New Zealand as whole, too) were those that occurred on roads or streets. The average annual claim cost of these road injury accidents is estimated to be \$19,774.

The second most costly claims were for injuries occurring in places of medical treatment (e.g. medical misadventure during hospital surgery). Next most costly were injuries occurring in recreation and sports places and in the home.

7

ROAD CRASH INJURY

This chapter provides data on road crashes and road crash casualties in New Plymouth District. In particular, it looks at hazard factors and other variables commonly associated with road crash injuries. This complements the mortality, hospitalisation and emergency department statistics related to road transport injuries described in previous chapters.

Trends in injury crashes

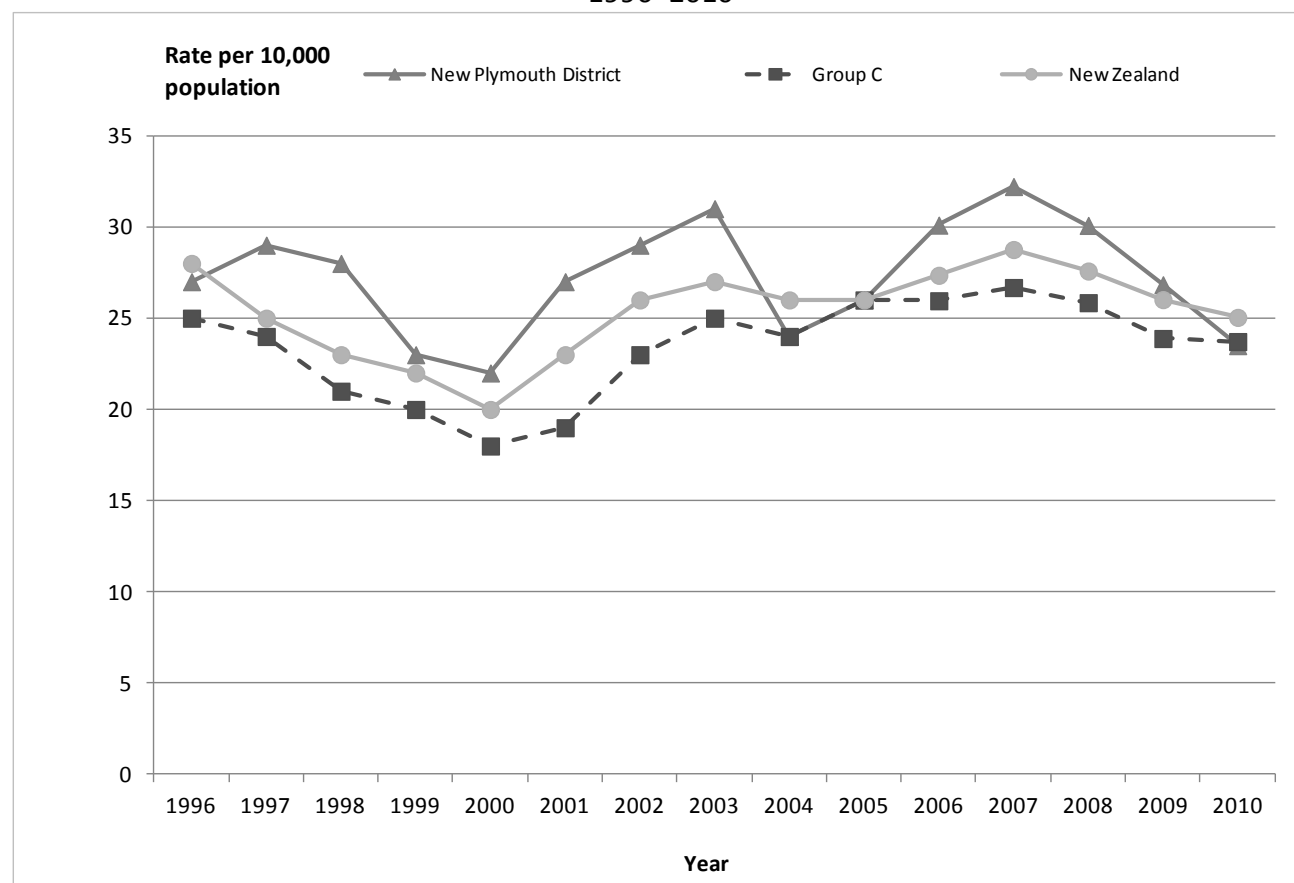
In 2010, the latest year for which figures are available, there were 172 injury road crashes in the New Plymouth District that were reported to the police. Since 1996, the number of injury road crashes in the district have fluctuated somewhat, with peaks in 1997 (199), 2003 (211) and 2007 (230) (appendix table 7.1).

Analysed on a population basis (rate per 10,000 people), the incidence of injury road crashes in New Plymouth District has also fluctuated somewhat in the 15 years from 1996 to 2010, including a low of 22 crashes per 10,000 people in 2000 to a high of 32 crashes per 10,000 people in 2007.

Over the 15 years, New Plymouth District injury crash rates have generally tracked higher than New Zealand as a whole and the Group C comparator. However, in certain years, 1996, 1999, 2000, 2004, 2005, 2009 and 2010 being examples, New Plymouth's rates have been quite close to New Zealand's and Group C's (figure 7.1 overleaf).

Figure 7.1

Injury Road Crash Rate New Plymouth District, Group C* and New Zealand 1996–2010



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.1.

Note: Years are calendar years 1 January to 31 December.
Crashes = number of crash incidents.

* Group C is a group of large NZ provincial towns and hinterland with populations of 35,000–75,000 and / or where rural crashes are less than 55 percent of all crashes in the area. Group C TLAs = New Plymouth District, Gisborne, Hastings, Kapiti Coast, Porirua, Rotorua, Timaru, Upper Hutt, Whanganui and Whangarei.

Trends in casualties

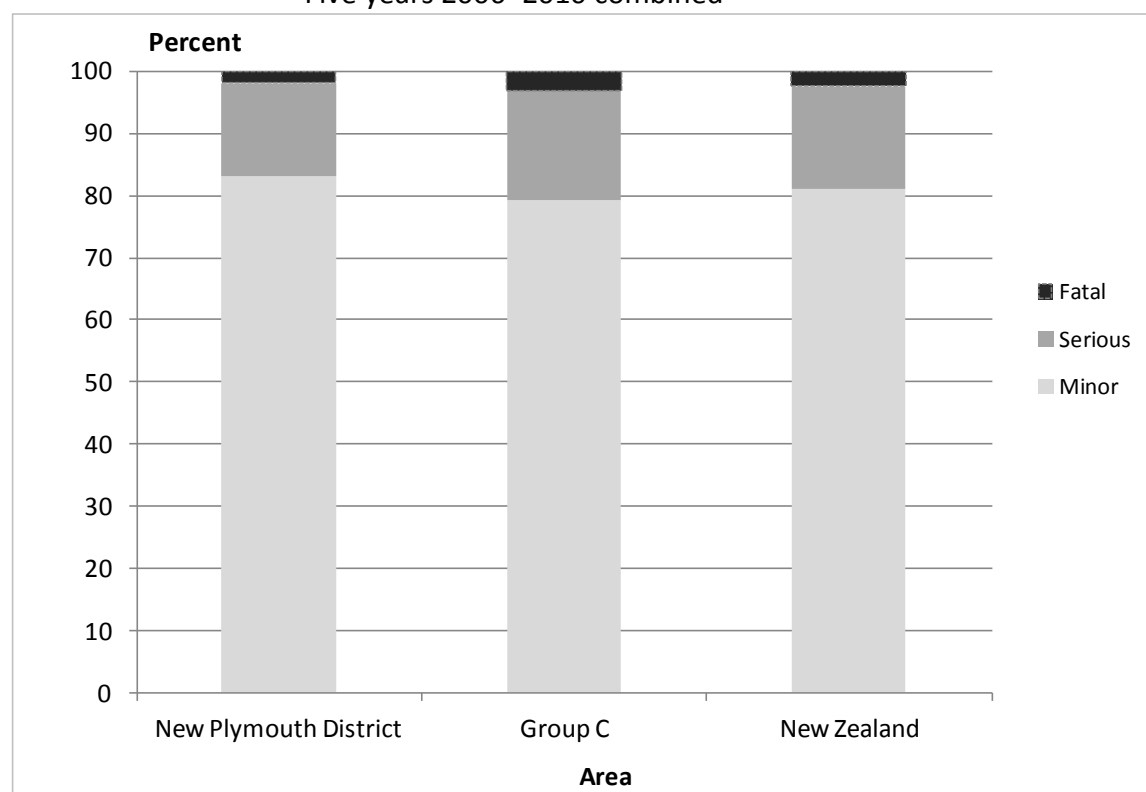
In the 172 road injury crashes that occurred in New Plymouth District in 2010, a total of 206 people were injured including 3 killed and 30 seriously injured.

For the five years 2006–2010, the proportions of New Plymouth District road injury casualties who sustained fatal, serious or minor injuries were fairly similar to New Zealand as a whole and to the Group C average (figure 7.2 overleaf). However, New Plymouth District had a slightly lower proportion of casualties with fatal or serious injuries (17%) compared with New Zealand and Group C (18% and 21% respectively).

Figure 7.2**Severity of Injuries - Road Crash Casualties**

New Plymouth District, Group C* and New Zealand

Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.2.

Note: Years are calendar years 1 January to 31 December.

Crashes = number of crash incidents.

Casualties = number of people injured in crashes (can be more than one per crash).

Fatal = death within 30 days of the crash.

Serious = fractures, concussion, internal injuries, crushing, severe cuts / lacerations, severe general shock needing medical treatment, injuries needing hospital treatment.

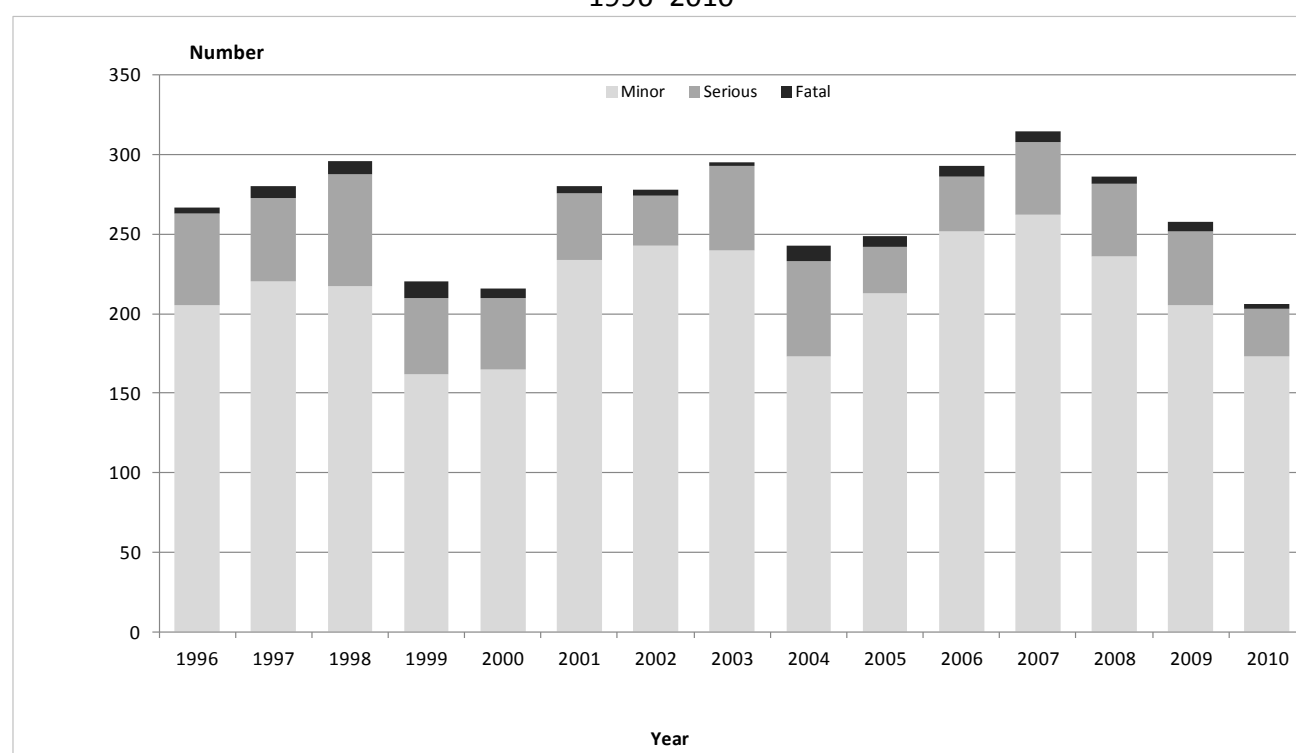
Minor = non-serious injuries requiring first aid, or that cause discomfort or pain e.g. sprains or bruises.

* Group C is a group of large NZ provincial towns and hinterland with populations of 35,000–75,000 and / or where rural crashes are less than 55 percent of all crashes in the area. Group C TLAs = New Plymouth District, Gisborne, Hastings, Kapiti Coast, Porirua, Rotorua, Timaru, Upper Hutt, Whanganui and Whangarei.

Compared with the previous 14 years, 2010 had one of the lowest road crash casualty totals (figure 7.3). Totals were also comparatively low in 1999 and 2000 but rose and fell in subsequent years without any clear overall downward or upward trend emerging.

Figure 7.3

Road Crash Injury Casualties
New Plymouth District, by severity of injury
1996–2010



Sources: McClellan et al. 2006, New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency. Data in appendix table 7.3.

Note: Years are calendar years 1 January to 31 December.

Casualties = number of people injured in crashes (can be more than one per crash).

Fatal = death within 30 days of the crash.

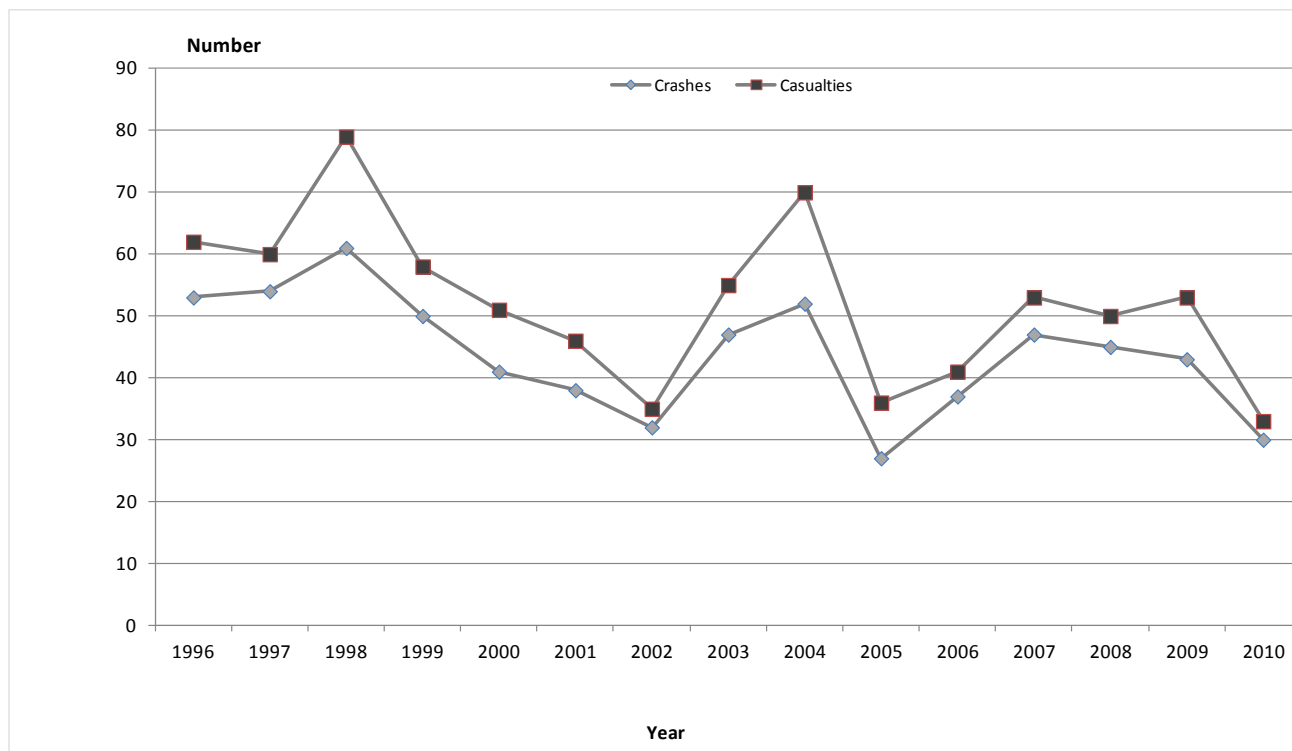
Serious = fractures, concussion, internal injuries, crushing, severe cuts / lacerations, severe general shock needing medical treatment, injuries needing hospital treatment.

Minor = non-serious injuries requiring first aid, or that cause discomfort or pain e.g. sprains or bruises.

Looking just at serious or fatal road crashes and casualties, there does appear to be a generally downward trend for these (figure 7.4 overleaf). This is despite totals spiking somewhat in 1998, 2003 and 2004, especially for casualties.

Figure 7.4

Serious or Fatal Road Crashes and Casualties
New Plymouth District
1996–2010



Sources: McClellan et al. 2006, New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency. Data in appendix table 7.3.

Note: Years are calendar years 1 January to 31 December.

Crashes = number of crash incidents.

Casualties = number of people injured in crashes (can be more than one per crash).

Fatal = death within 30 days of the crash.

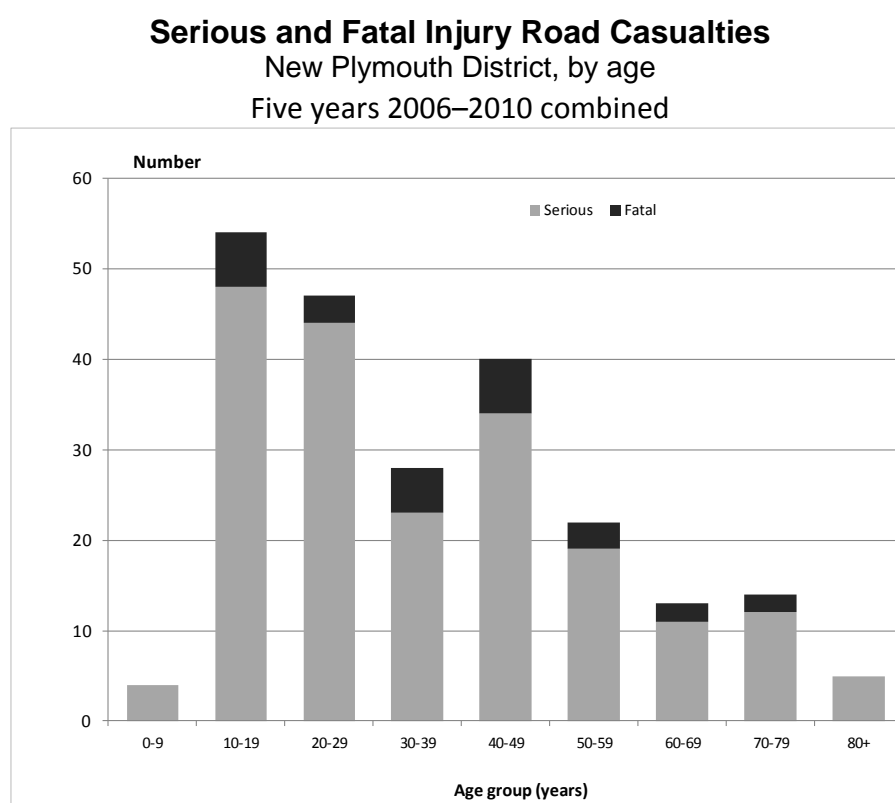
Serious = fractures, concussion, internal injuries, crushing, severe cuts / lacerations, severe general shock needing medical treatment, injuries needing hospital treatment.

Age of casualties

Altogether 230 people were killed or seriously injured on New Plymouth District roads in the five years from 2006 to 2010. In terms of age, the largest numbers seriously injured or killed were those aged 10–19; a total of 54 in the five years (see figure 7.5) making up 23% of the district's serious and fatal road casualties.²⁶

People aged 20–29 and 40–49 also featured heavily in the district's road casualty statistics comprising 20 and 17% of serious and fatal road casualties, respectively.

Figure 7.5



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.4.

Note: Years are calendar years 1 January to 31 December.
Casualties = number of people injured in crashes (can be more than one per crash).
Fatal = death within 30 days of the crash.

Serious = fractures, concussion, internal injuries, crushing, severe cuts / lacerations, severe general shock needing medical treatment, injuries needing hospital treatment.

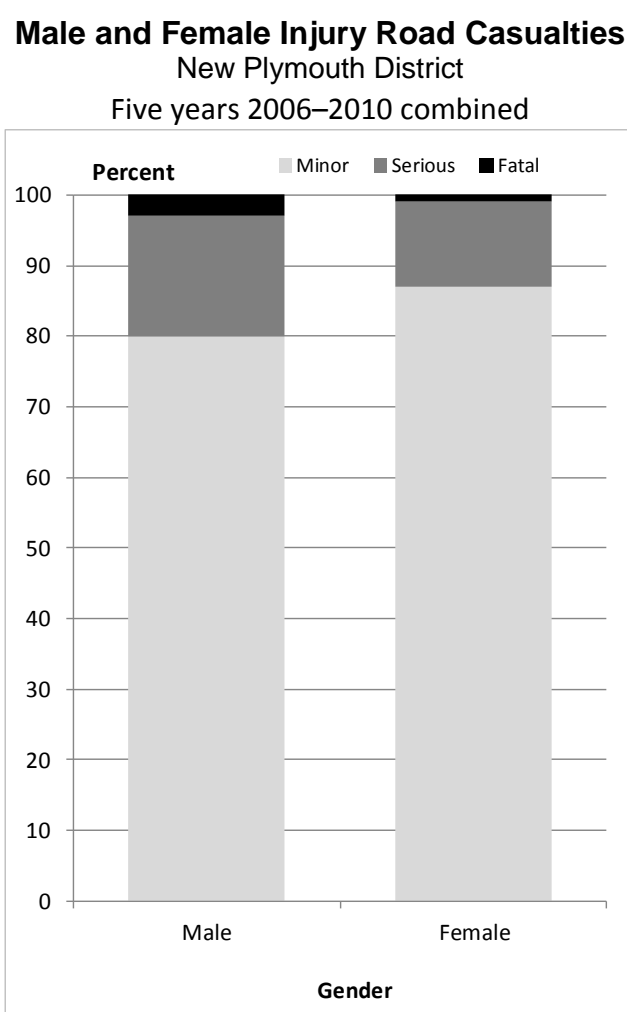
²⁶ In the 10–19 age group, those aged 15–19 are the most likely to feature in road casualty statistics. Go to appendix table 7.7 for New Plymouth District road casualty statistics presented in 5-year age bands.

Gender of casualties

Altogether, 761 males and 593 females were injured in road crash injuries in New Plymouth District in the five years from 2006 to 2010. This is an average of 152 male and 119 female casualties per year with males making up 56% and females 44% of the total injured. In particular, males and females aged 15–19 and 20–24 featured most prominently in the statistics (see appendix table 7.5 for details).

Looking only at serious and fatal road crash injuries, males were more likely than females to sustain serious or fatal road crash injuries (figure 7.6). Injuries sustained by females in road crashes were more likely to be minor.

Figure 7.6



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency. Data in appendix table 7.6.

Note: Years are calendar years 1 January to 31 December.
Casualties = number of people injured in crashes (can be more than one per crash).
Fatal = death within 30 days of the crash.

Serious = fractures, concussion, internal injuries, crushing, severe cuts / lacerations, severe general shock needing medical treatment, injuries needing hospital treatment.
Minor = non-serious injuries requiring first aid, or that cause discomfort or pain e.g. sprains or bruises.

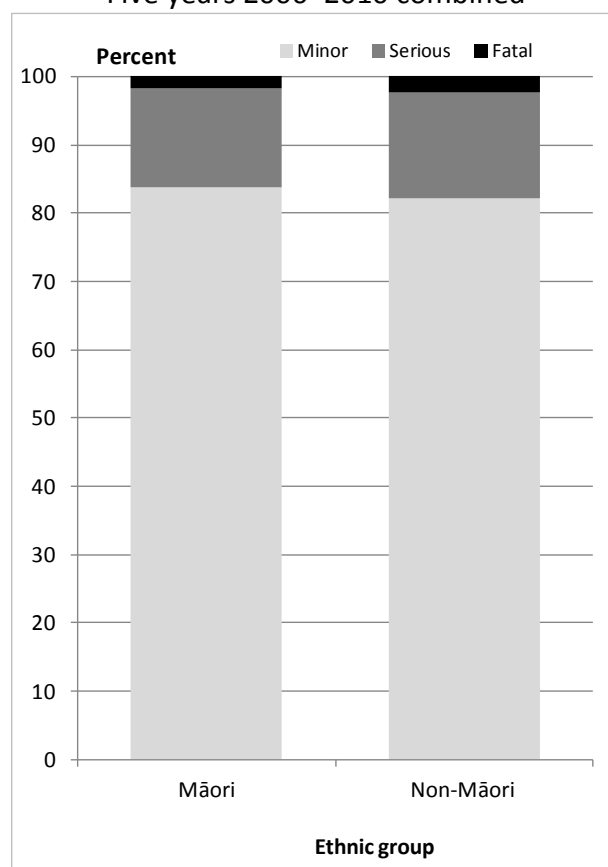
Māori and non-Māori casualties

The proportions of minor, serious and fatal road injuries sustained by Māori were quite similar to non-Māori (figure 7.7). For example, 14% of Māori road crash casualties in New Plymouth District were seriously injured compared to 15% of non-Māori casualties.

Figure 7.7

Māori and non-Māori Injury Road Casualties New Plymouth District

Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.7.

Note: Years are calendar years 1 January to 31 December.
Casualties = number of people injured in crashes (can be more than one per crash).
Fatal = death within 30 days of the crash.

Serious = fractures, concussion, internal injuries, crushing, severe cuts / lacerations, severe general shock needing medical treatment, injuries needing hospital treatment.

Minor = non-serious injuries requiring first aid, or that cause discomfort or pain e.g. sprains or bruises.

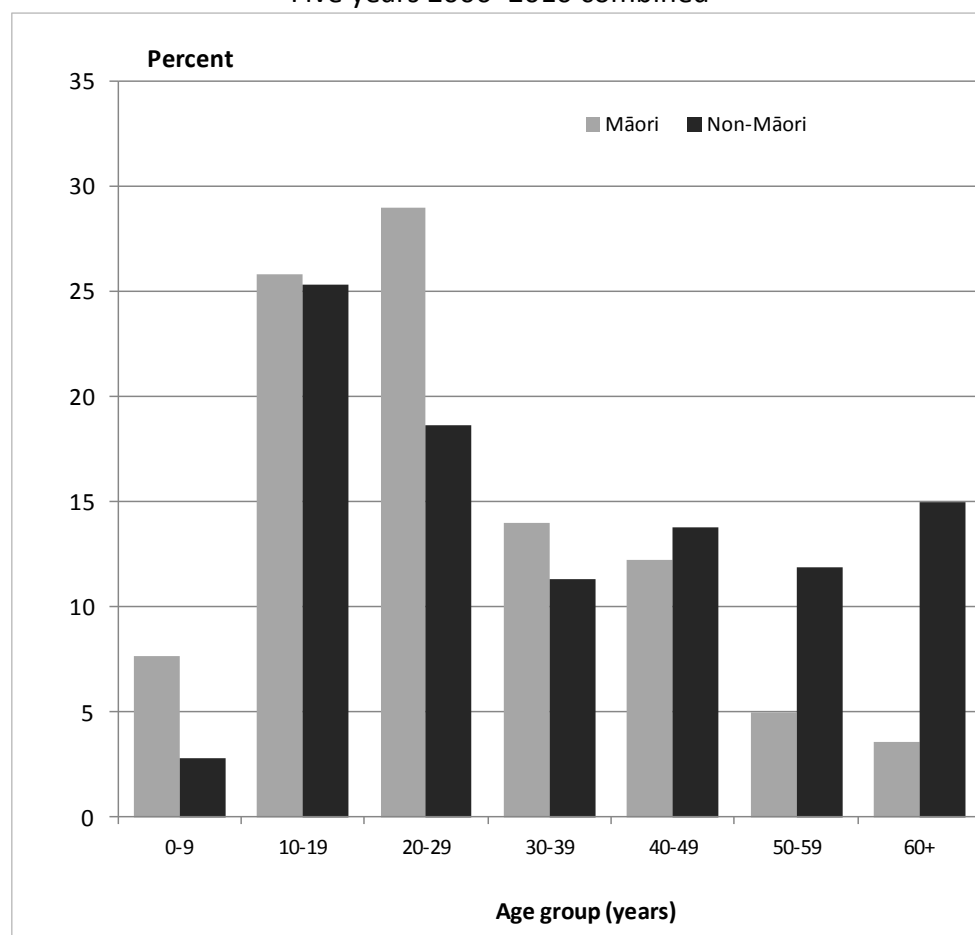
Chart excludes casualties with unknown ethnic group.

The largest proportion of Māori road injury casualties was aged 20–29 (29%, see figure 7.8). The second largest was aged 10–19 (26%). Thus well over half of all New Plymouth District’s Māori road injury casualties were young people.

Compared to non-Māori, it was much more common for Māori aged 20–29 to be road injury casualties. It was uncommon for them to be aged 50 or more. In part this is because the district’s Māori population has proportionately more young people and fewer older people in it than the non-Māori population (see chapter 2).

Figure 7.8

Māori and non-Māori Injury Road Casualties
New Plymouth District, by age
Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.8.

Note: Years are calendar years 1 January to 31 December.

Casualties = number of people injured in crashes (can be more than one per crash).

Chart excludes casualties with unknown ethnic group and/or unknown age.

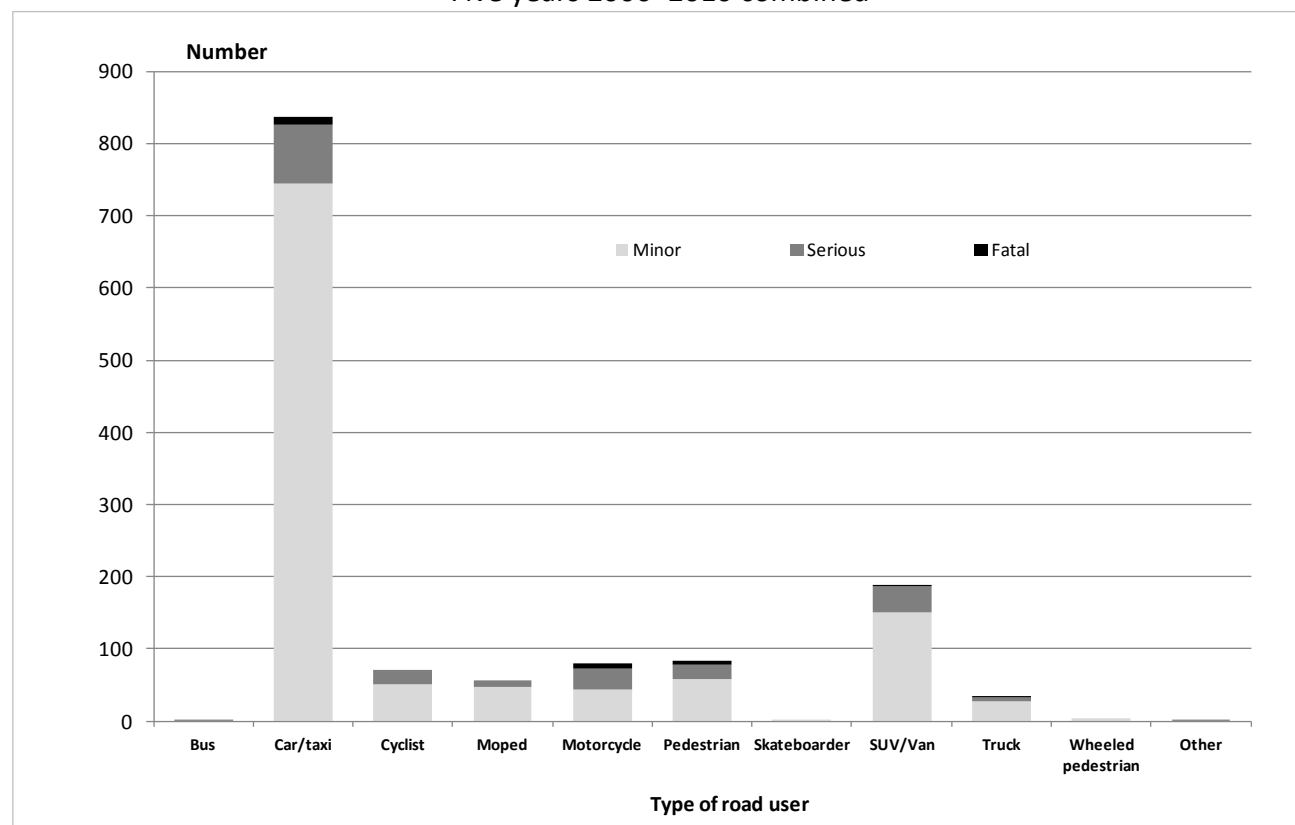
Road user casualties

Of the 1,358 people injured in road traffic crashes in New Plymouth District between 2006 and 2010, 832 or nearly two-thirds (62%) were drivers or passengers in cars, including taxis (figure 7.9).

The next highest group was drivers or passengers in SUVs and vans (14% of casualties). Motorcyclists made up 6% of road crash casualties, as did pedestrians.

Figure 7.9

Type of Road Users Who Are Injury Road Casualties New Plymouth District, by severity of injury Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency. Data in appendix table 7.9.

Note: Years are calendar years 1 January to 31 December.
Casualties = number of people injured in crashes (can be more than one per crash).
Fatal = death within 30 days of the crash.

Serious = fractures, concussion, internal injuries, crushing, severe cuts / lacerations, severe general shock needing medical treatment, injuries needing hospital treatment.

Minor = non-serious injuries requiring first aid, or that cause discomfort or pain e.g. sprains or bruises.

SUV = sport utility vehicle.

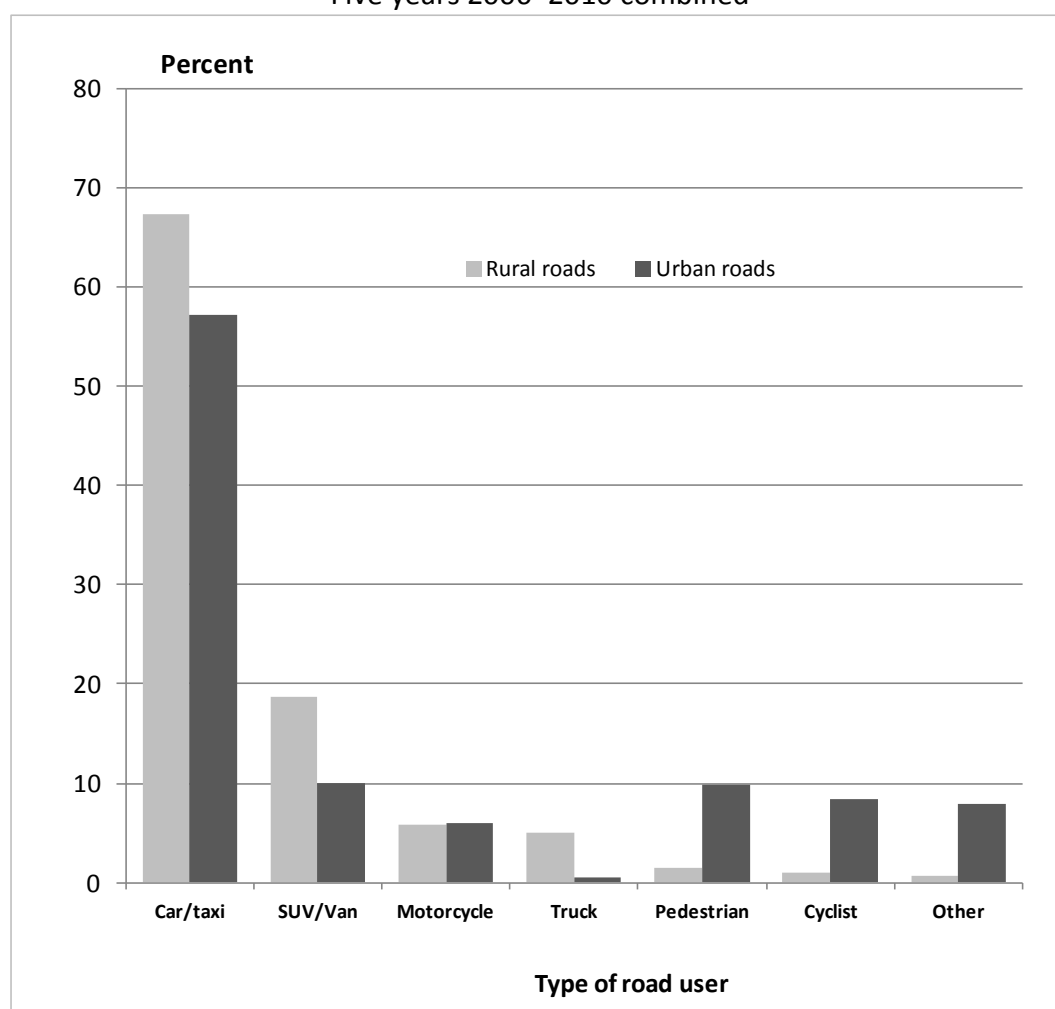
As might be expected, pedestrians and cyclists made up a greater share of the casualties on urban roads compared with rural roads (figure 7.10).

Drivers and passengers in cars, SUVs/vans and trucks featured more prominently in rural road casualties.

By contrast, motorcyclists comprised a similar share of both rural and urban road casualties (6%).

Figure 7.10

Rural and Urban Injury Road Casualties
New Plymouth District, by type of road user
Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.10.

Note: Years are calendar years 1 January to 31 December.

Casualties = number of people injured in crashes (can be more than one per crash).

SUV = sport utility vehicle.

At fault road users

Injury road crashes in New Plymouth District were much more likely to be fully or partly the fault of male road users rather than female road users (figure 7.11). In particular, high numbers of injury road crashes were fully or partly caused by males aged 15–19 and 20–24.

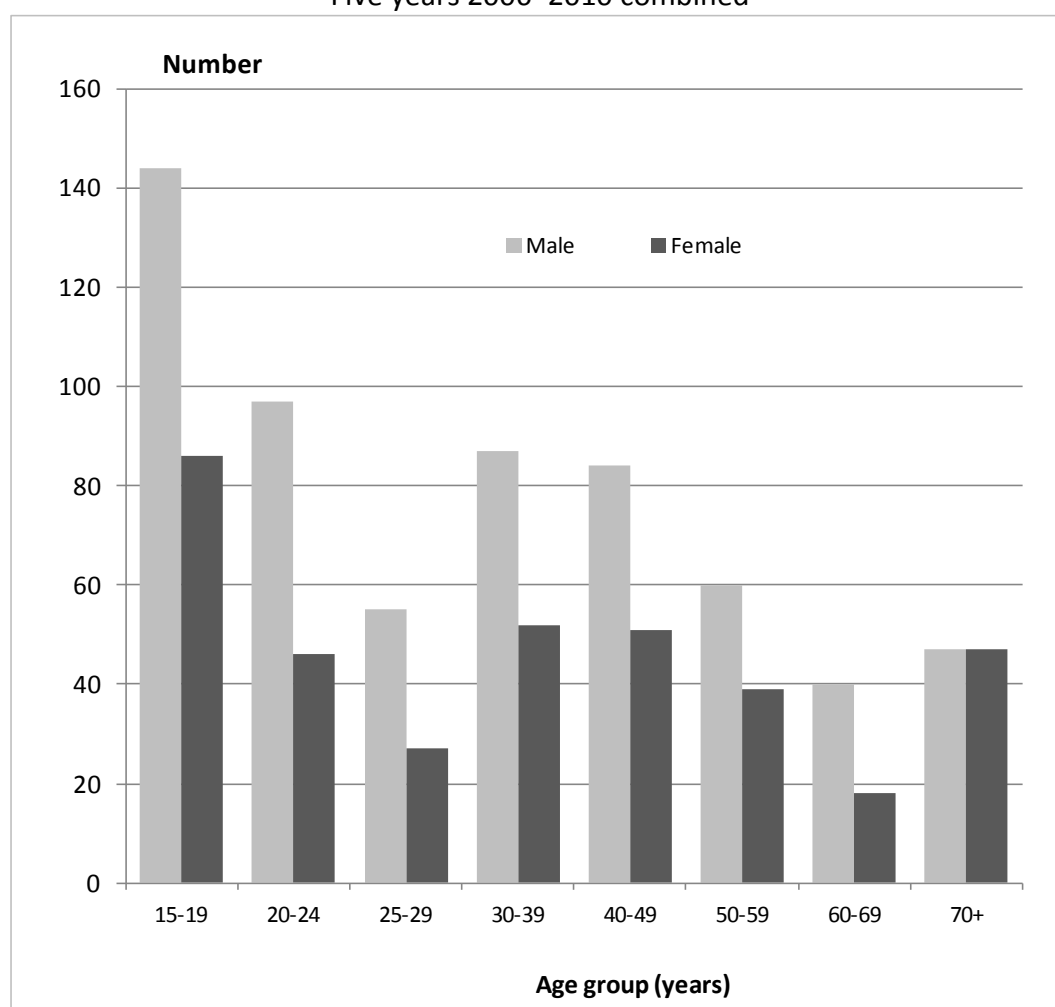
However, females aged 15–19 also caused a substantial number of injury road crashes. By contrast, females aged 60–69 and 25–29 were the least prominent perpetrators of road injury crashes. Only females aged 70+ could be considered to be causing road injury crashes to the same extent as their male counterparts.

Figure 7.11

At Fault or Partly At Fault For Injury Road Crashes

New Plymouth District, by age and gender

Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency. Data in appendix table 7.11.

Note: Years are calendar years 1 January to 31 December.
Crashes = number of crash incidents.

Casualties per vehicle kilometres travelled

Comparing the number of road accident casualties occurring per vehicle kilometres travelled is one way of estimating the relative safety or risk of road travel in different parts of New Zealand.

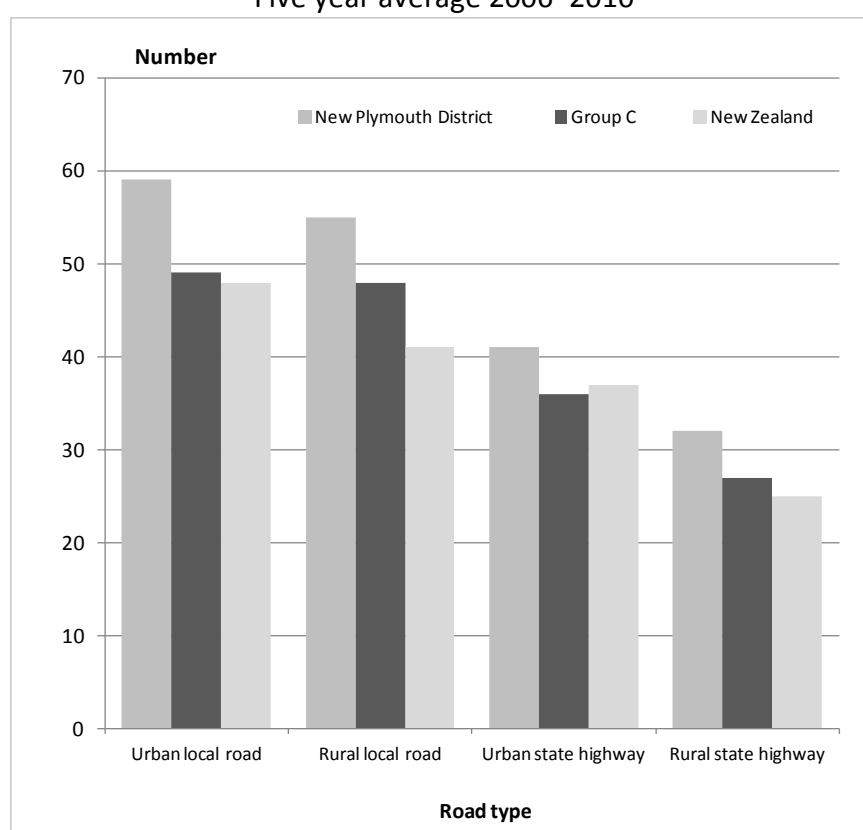
In New Plymouth District during the five years 2006 to 2010, for every 100 million vehicle kilometres travelled on urban local roads, on average an estimated 59 people were injured in vehicle accidents on these roads (figure 7.12). This is a higher casualty rate than for urban local roads in Group C areas and New Zealand as a whole (49 and 48 casualties per 100 million vehicle kilometres travelled, respectively).

The district's casualty rates per vehicle kilometres travelled on rural local roads, urban state highways and rural state highways were also higher than Group C's and New Zealand's (figure 7.12).

Figure 7.12

Number of Casualties per 100 million Vehicle Kilometres Travelled

New Plymouth District, Group C* and New Zealand, by type of road
Five year average 2006–2010



Source: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency. Data in appendix table 7.12.

Note: Years are calendar years 1 January to 31 December.

Casualties = number of people injured in crashes (can be more than one per crash).

*Group C is a group of large NZ provincial towns and hinterland with populations of 35,000–75,000 and / or where rural crashes are less than 55 percent of all crashes in the area. Group C TLAs = New Plymouth District, Gisborne, Hastings, Kapiti Coast, Porirua, Rotorua, Timaru, Upper Hutt, Whanganui and Whangarei.

Crashes by type of road

On average in 2006–2010, each year 2 people died on local roads and 4 died on state highways. Another 19 people were seriously injured on local roads and 15 were seriously injured on state highways (appendix table 7.13).

Timing of crashes

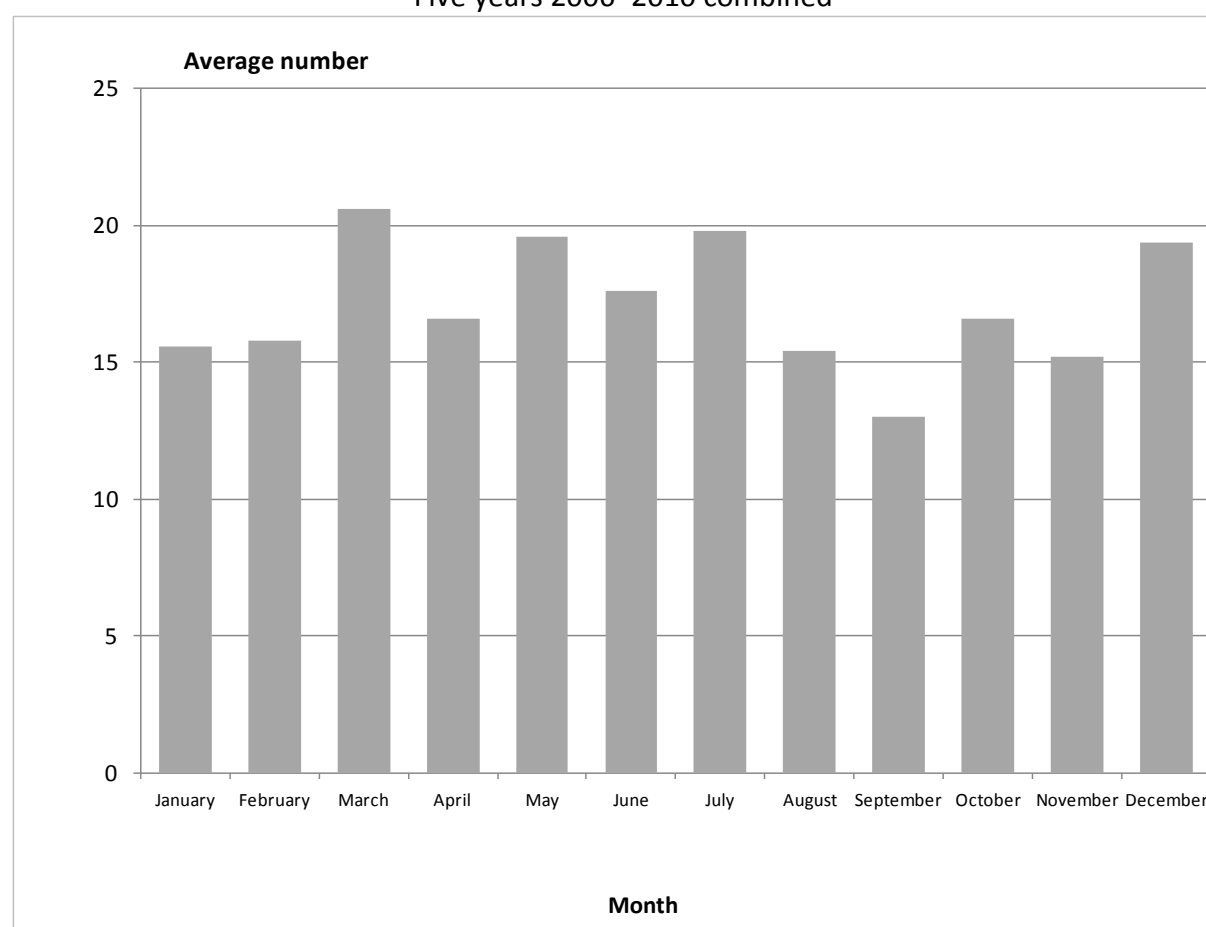
Month of year

Injury road crashes in New Plymouth District are more frequent in some months than others. In the five years from 2006 to 2010, injury crashes were most common in March, May, July and December and least common in September (figure 7.2).

Figure 7.13

Average Number of Injury Road Crashes Per Month

New Plymouth District
Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency. Data in appendix table 7.14.

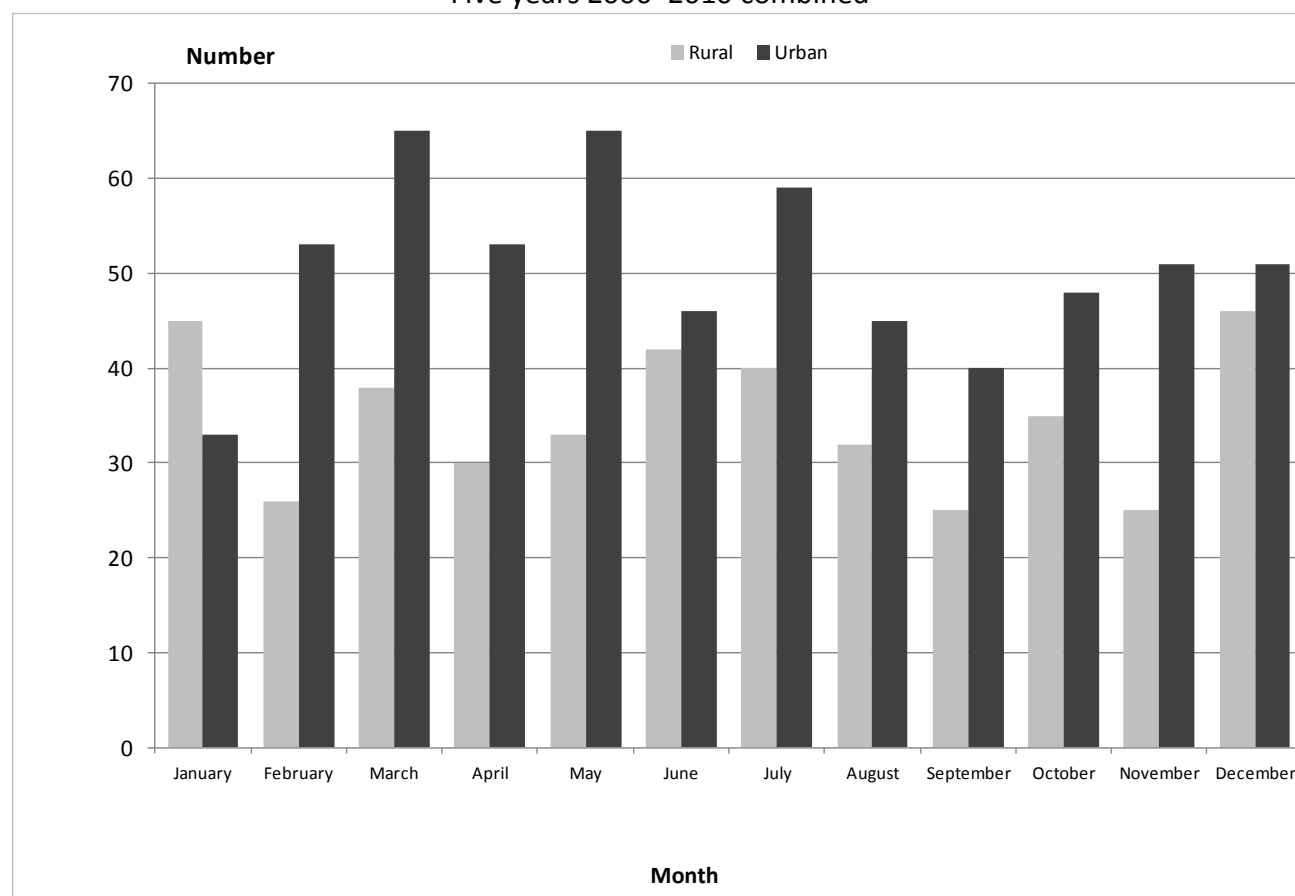
Note: Years are calendar years 1 January to 31 December.
Crashes = number of crash incidents.

In New Plymouth District, more injury road crashes occur on urban roads than rural roads. Of the 1,026 injury road crashes reported to police in the five years from 2006 to 2010, 609 (59%) occurred on urban roads and 417 (41%) were on rural roads.

March, May and July are the months with the highest numbers of urban road injury crashes (figure 7.14). Injury crashes on rural roads are most common in the summer holiday months of December and January and the winter months of June and July.

Figure 7.14

Total Rural and Urban Injury Road Crashes Per Month
New Plymouth District
Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.14.

Note: Years are calendar years 1 January to 31 December.
Crashes = number of crash incidents.

Day of the week

In New Plymouth District, there was an average of 205 injury road crashes per year in the five years from 2006 to 2010. This was an average of 4 injury road crashes a week.

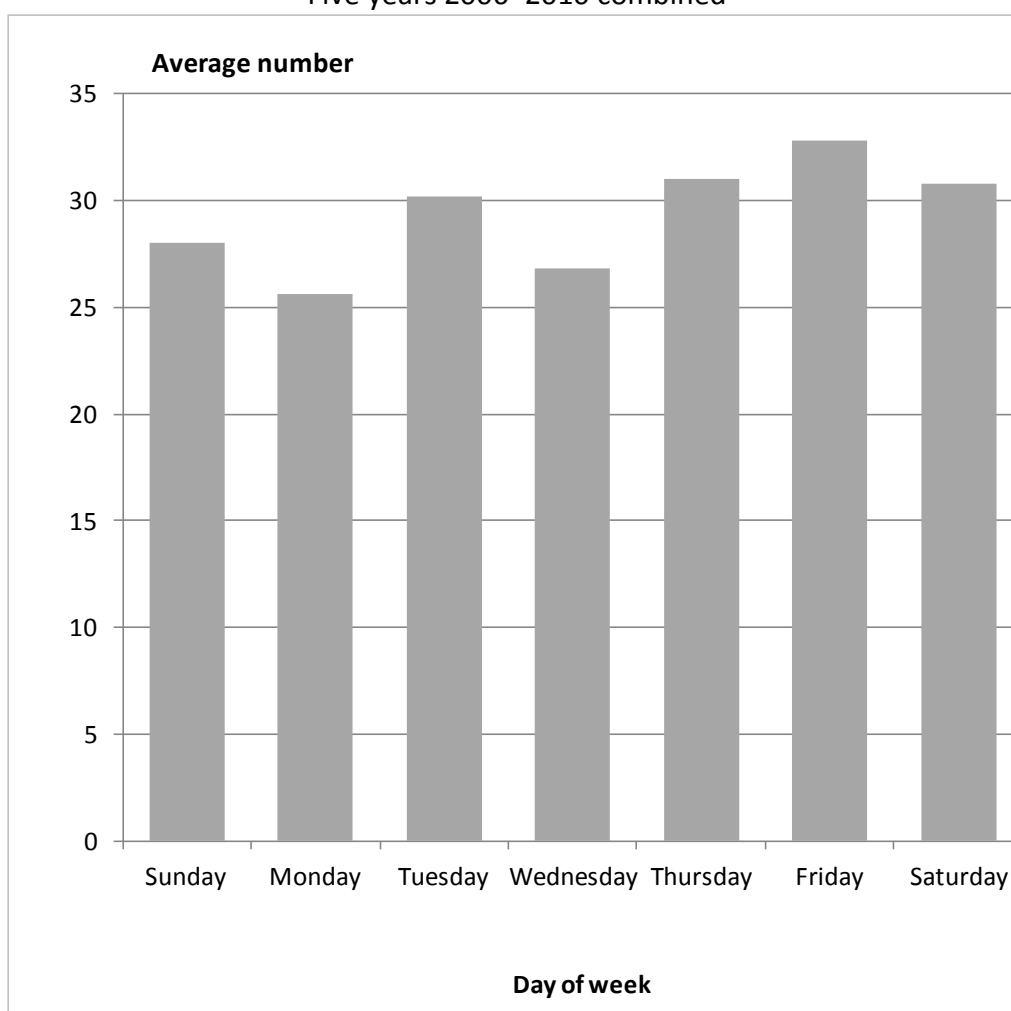
Certain days of the week were more likely than others to have injury crashes occurring on them. Fridays, Thursdays, Saturdays and Tuesdays had the highest average annual numbers of injury road crashes. Mondays had the lowest (figure 7.15).

Figure 7.15

Average Number of Injury Road Crashes By Day of Week

New Plymouth District

Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.15.

Note: Years are calendar years 1 January to 31 December.
Crashes = number of crash incidents.

Injury crashes on rural roads were the most frequent on Sundays and least frequent on Wednesdays (figure 7.16).

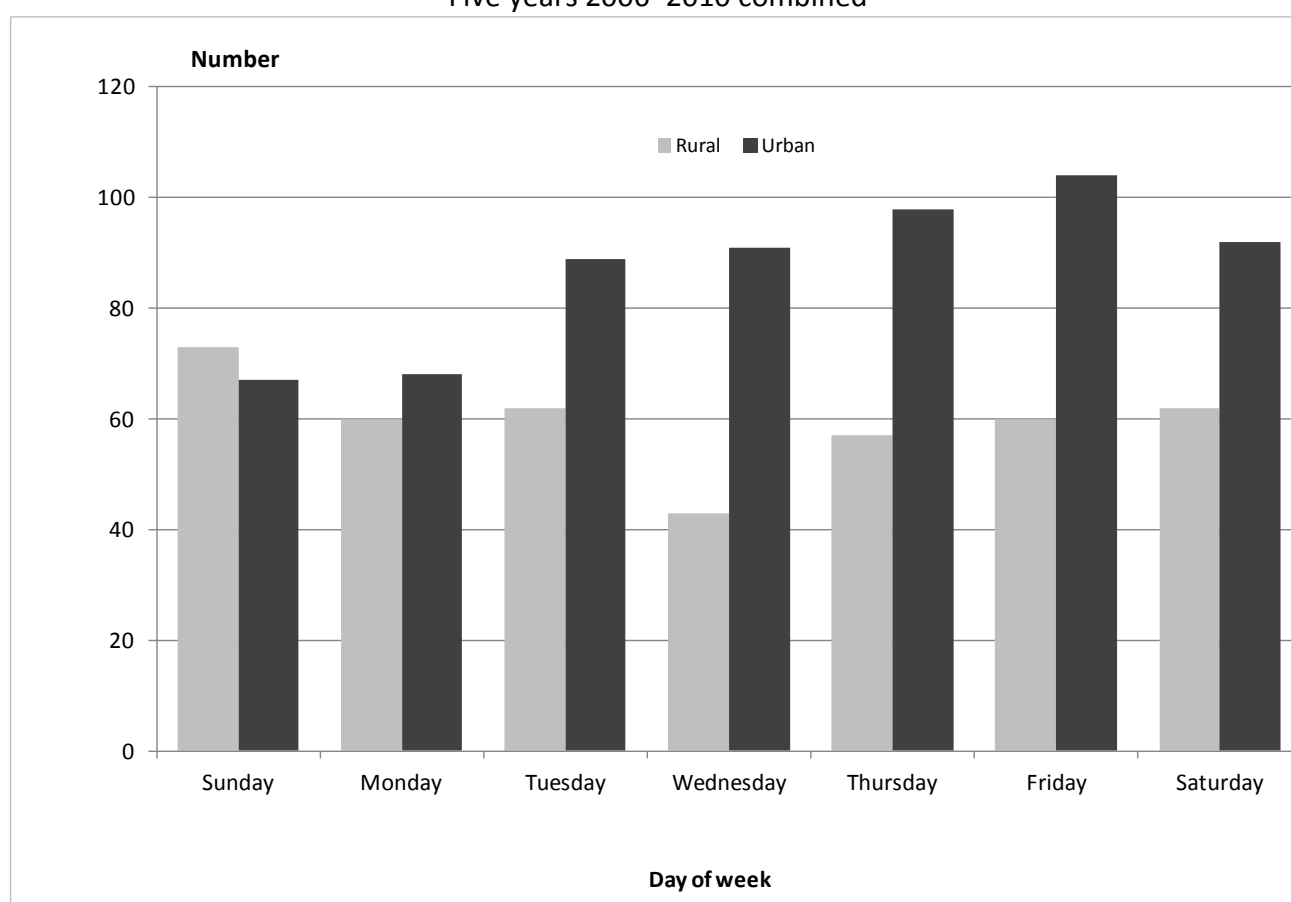
By contrast, Fridays were the days with the highest number of injury crashes on urban roads. Saturdays and the weekdays immediately before Friday also had high urban road injury crash totals. Mondays had the lowest urban crash totals.

Figure 7.16

Total Rural and Urban Injury Road Crashes By Day of Week

New Plymouth District

Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.15.

Note: Years are calendar years 1 January to 31 December.
Crashes = number of crash incidents.

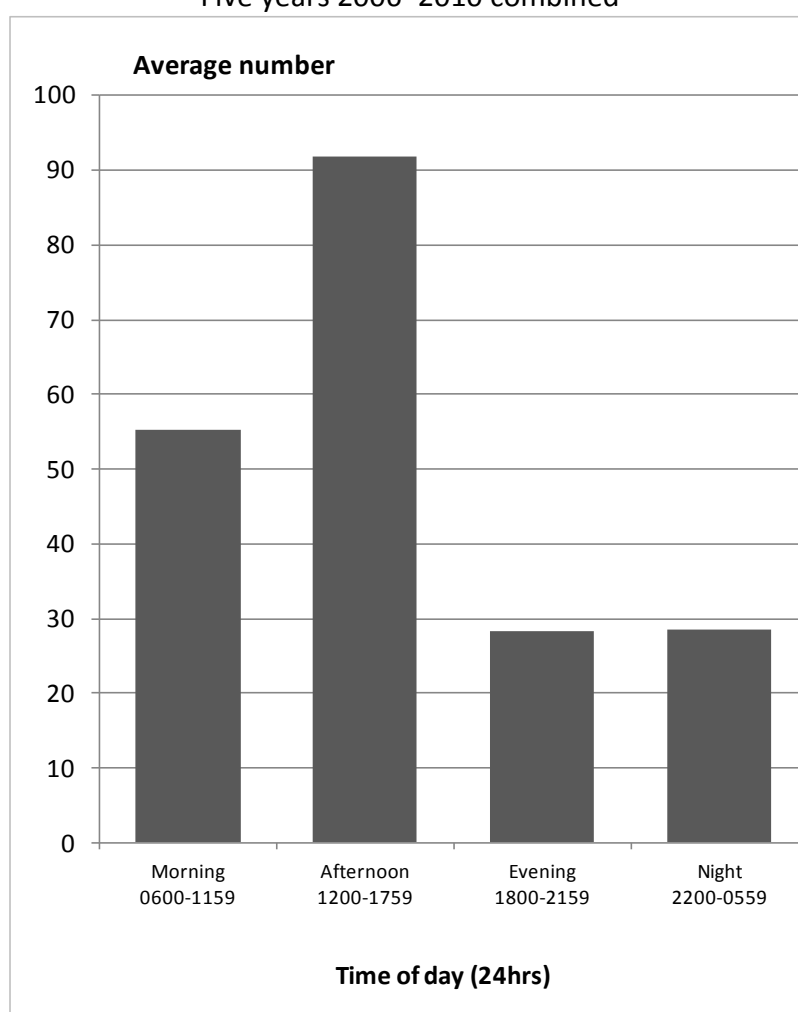
Time of the day

In New Plymouth District, injury road crashes most commonly occur in the afternoons between midday and six o'clock (figure 7.17). Close to half (45%) of all injury crashes happen in this part of the day.

Another 27% of injury crashes happen in the mornings between six and noon. Injury crashes are less common in the evenings and overnight.

Figure 7.17

Average Number of Injury Road Crashes By Time of Day New Plymouth District Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.

Data in appendix table 7.16.

Note: Years are calendar years 1 January to 31 December.

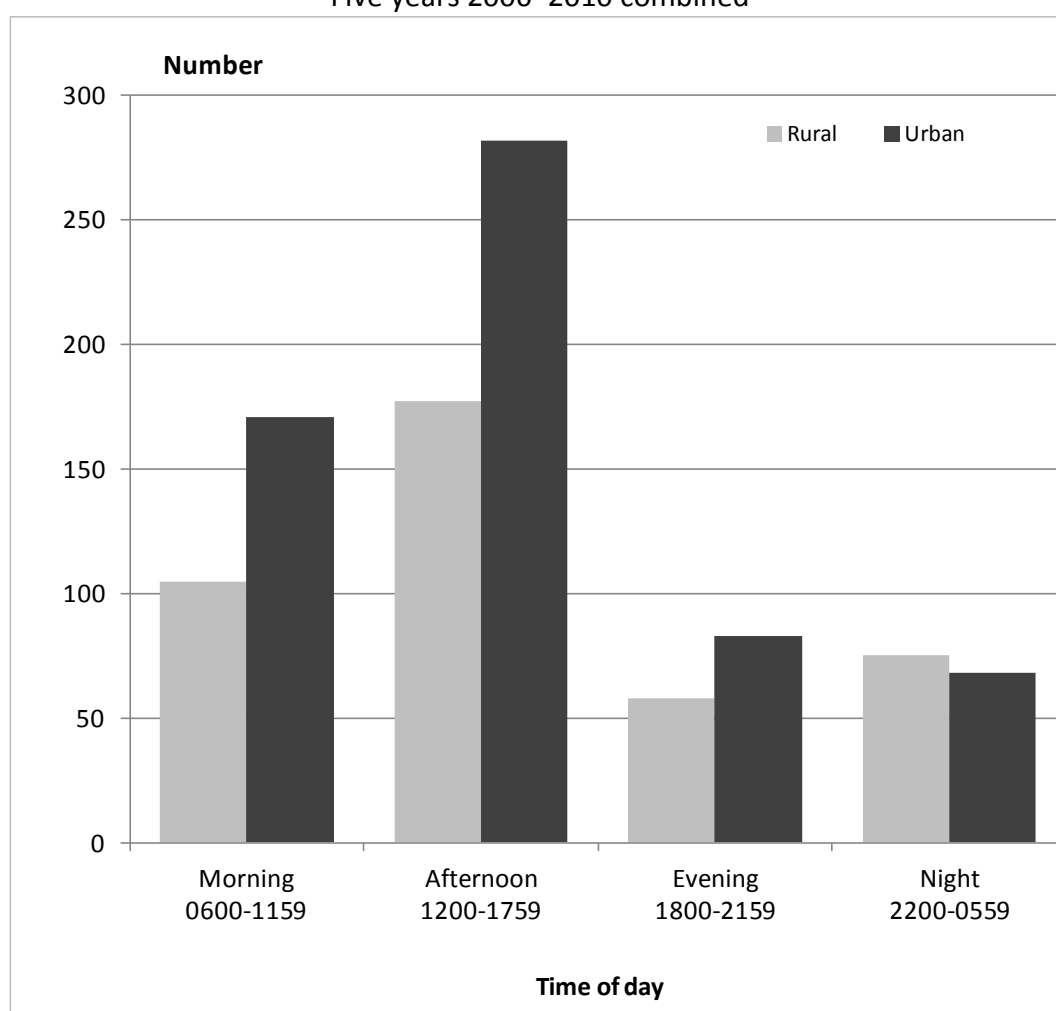
Crashes = number of crash incidents. Excludes crashes where time of day is unknown.

Injury crashes on New Plymouth District urban roads are most likely to occur in the afternoon (46%) and morning (28%). Similarly, injury crashes on the district's rural roads also occur most often in the afternoon (42%) and morning (25%).

Although there are more urban road crashes than rural road crashes in the mornings, afternoons and evenings, there are slightly more rural road crashes in the night time hours from 10pm to 6am (figure 7.18).

Figure 7.18

Total Rural and Urban Injury Road Crashes By Time of Day
New Plymouth District
Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.16.

Note: Years are calendar years 1 January to 31 December.
Crashes = number of crash incidents. Excludes crashes where time of day is unknown.

Compared to other days of the week, a relatively high proportion of Saturday's and Sunday's injury road crashes occur at night time (19 and 29% respectively, see figure 7.19). This probably reflects the impact of Friday and Saturday night social activities carrying on into the early hours of the next day.

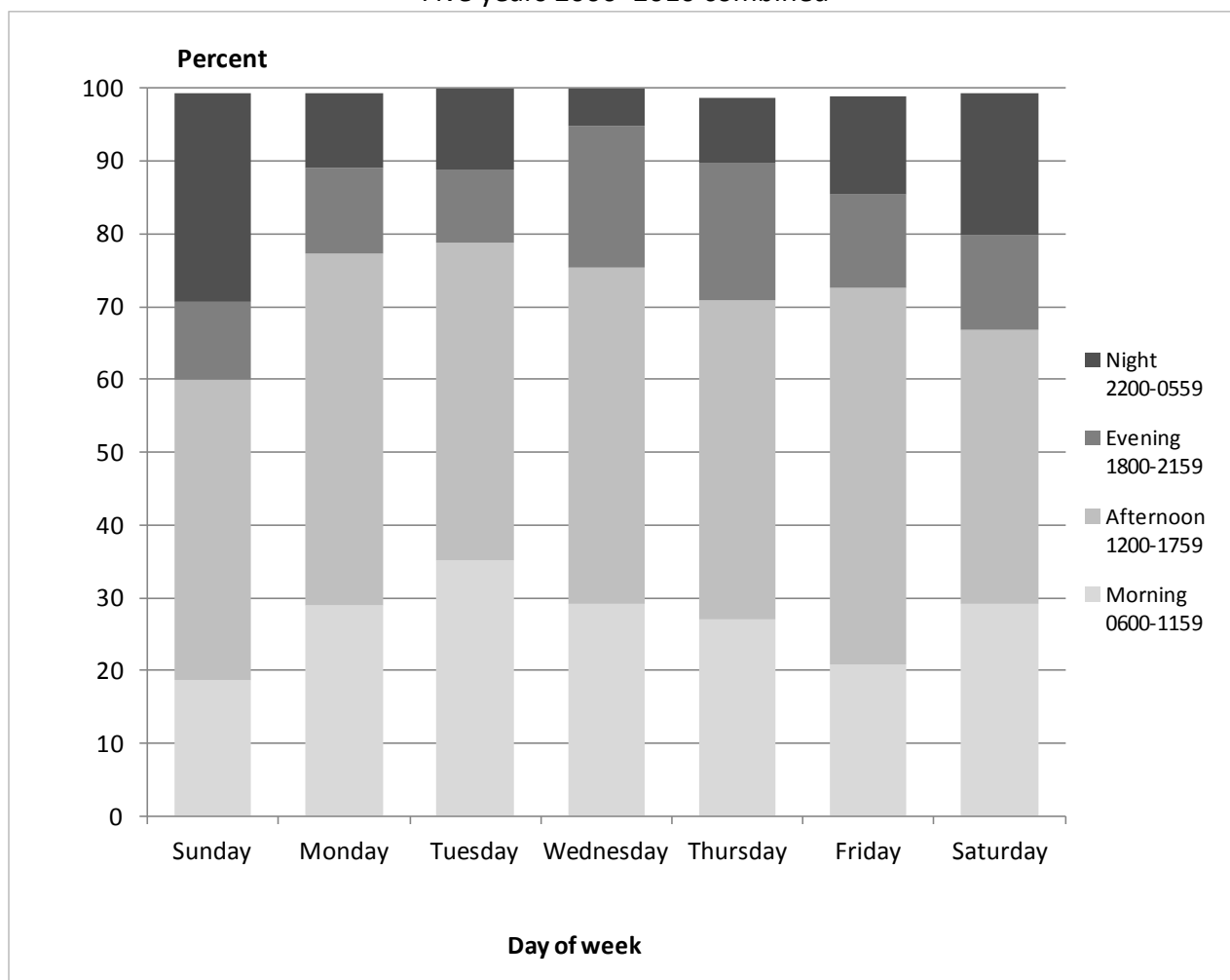
Wednesdays and Thursdays have the lowest proportion of their injury road crashes occurring at night time (5 and 9% respectively), with a correspondingly higher proportion occurring in the evening.

Figure 7.19

Injury Road Crashes By Time of Day and Day of Week

New Plymouth District

Five years 2006–2010 combined



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.17.

Note: Years are calendar years 1 January to 31 December.

Crashes = number of crash incidents. Totals may not sum to 100 as chart excludes crashes where time of day is unknown.

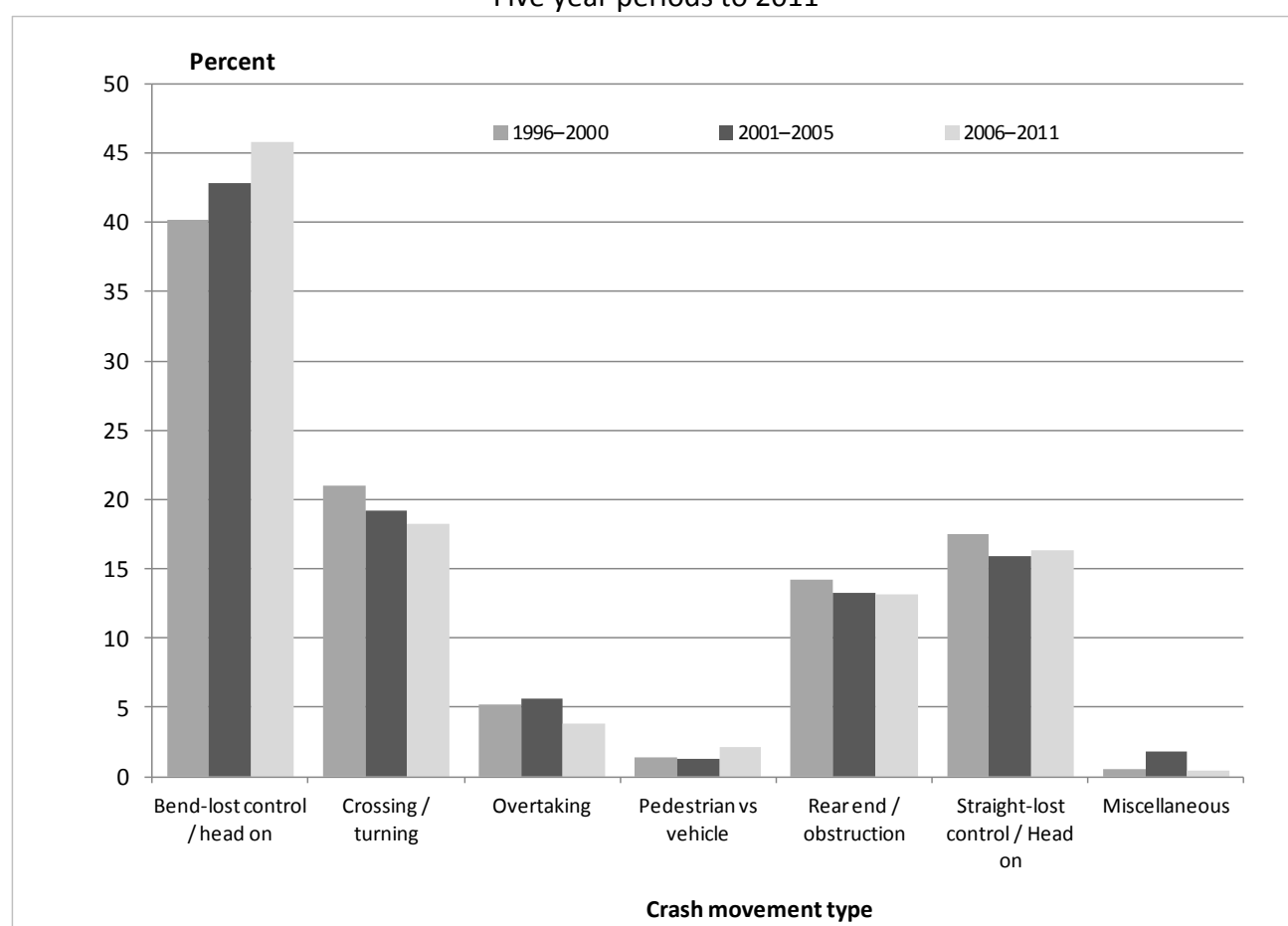
Crash movements

Crashes on road bends associated with either losing control and/or crashing into oncoming traffic is by far the most common crash movement type leading to injury crashes on rural roads. Indeed, this type of crash movement type has featured in an increasing share of the rural road injury crashes occurring in New Plymouth District since 1996 (figure 7.20).

Crashes on rural roads involving crossing or turning movements (typically at intersections) have become slightly less prominent over this period, as have crashes involving loss of control or head-on crashes on straight roads.

Figure 7.20

Rural Road Injury Crashes – Crash Movement Type New Plymouth District Five year periods to 2011



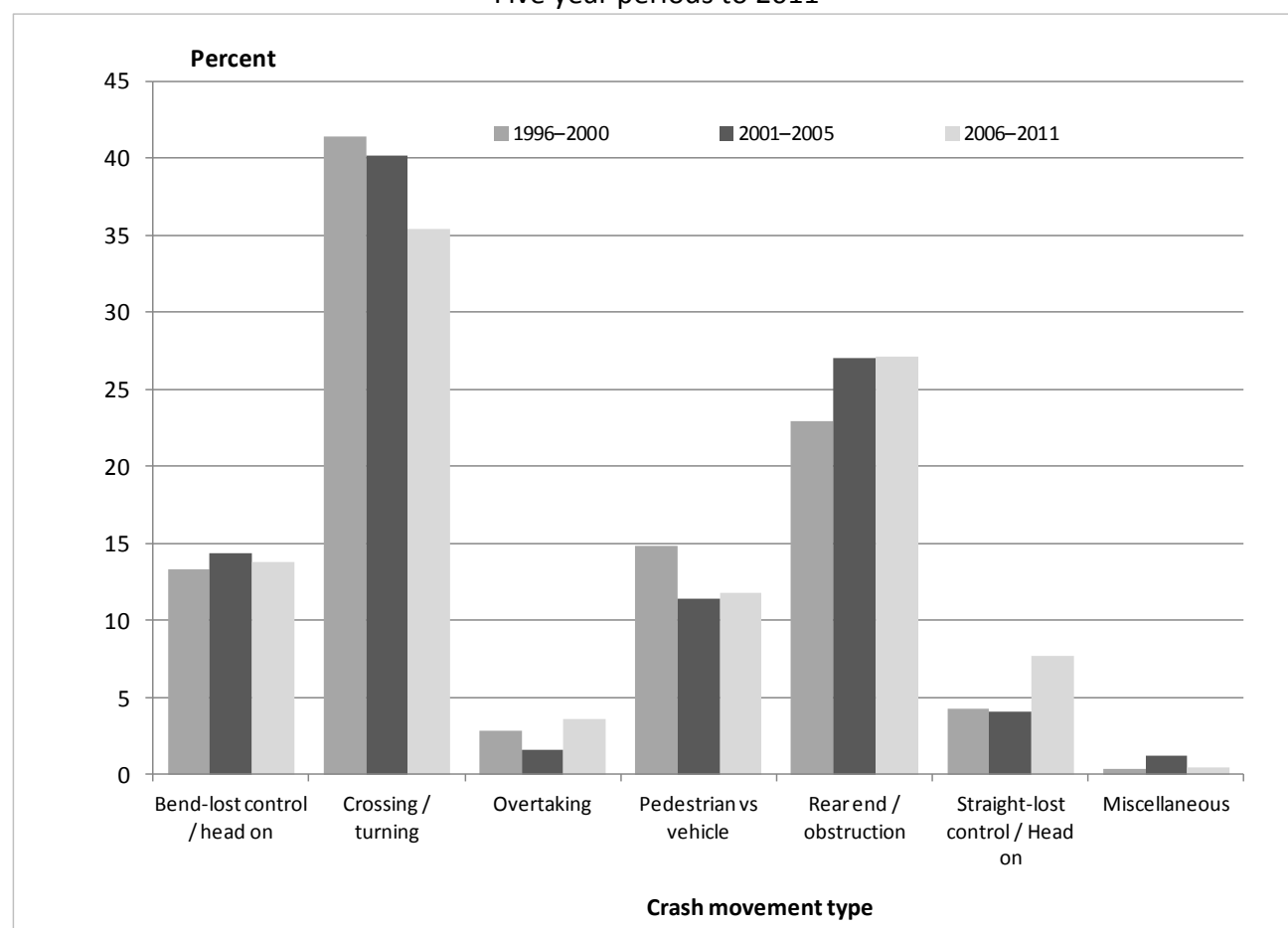
Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.18.

Note: Years are financial years 1 July to 31 June.
Crashes = number of crash incidents.

Although reducing in recent years, crossing or turning continues to be the commonest crash movement resulting in injury crashes on urban roads (figure 7.21). Next most common is rear-end collisions or collisions with obstacles. Contact between a pedestrian and a vehicle is also a prominent feature of injury crashes on urban roads.

Figure 7.21

Urban Road Injury Crashes – Crash Movement Type
New Plymouth District
Five year periods to 2011



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.18.

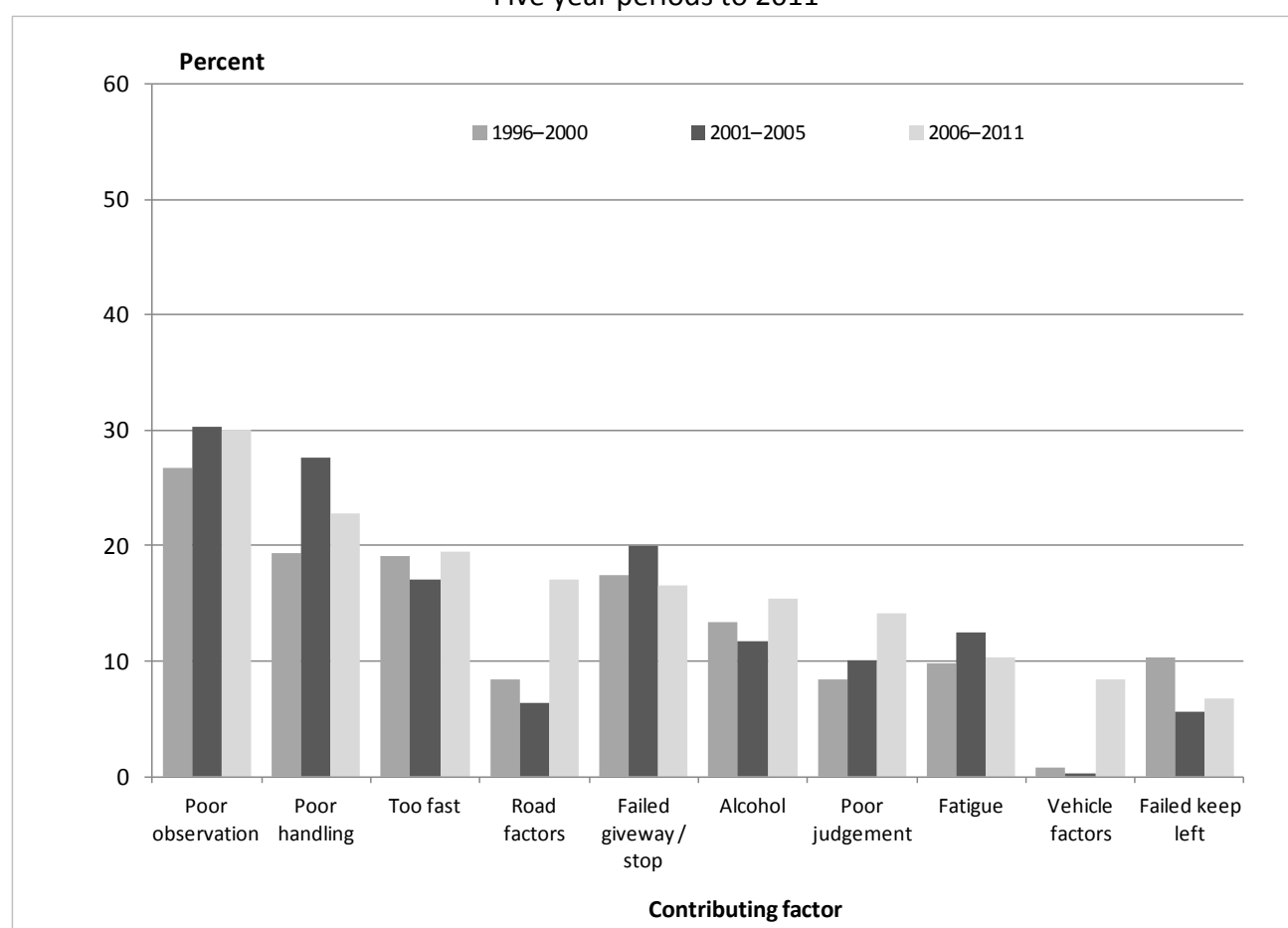
Note: Years are financial years 1 July to 31 June.
Crashes = number of crash incidents.

Contributing factors to crashes

In the five years 2006 to 2011, the biggest contributing factor to injury crashes on New Plymouth District rural roads was poor observation. This played a role in 30% of rural crashes (figure 7.22). Next in order of importance was poor handling, followed by speed ('too fast') and road factors.

Poor observation, road factors, poor judgement and vehicle factors have become more prominent contributing factors to rural road crashes in the last decade.

Figure 7.22
Top 10 Contributing Factors to Rural Road Injury Crashes
 New Plymouth District
 Five year periods to 2011



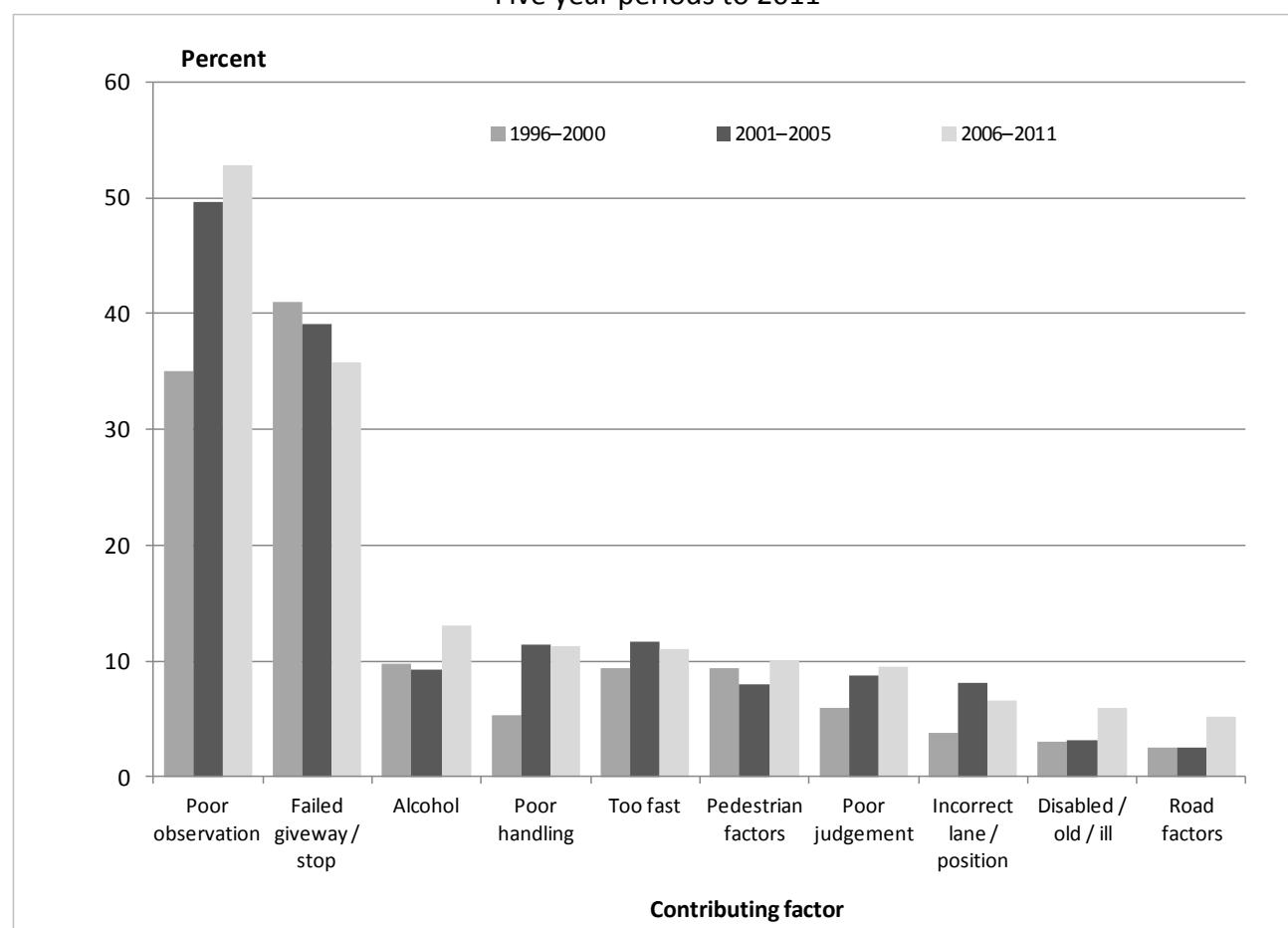
Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
 Data in appendix table 7.19.

Note: Years are financial years 1 July to 31 June.
 Crashes = number of crash incidents.

As with rural roads, on New Plymouth District urban roads the biggest contributing factor to injury crashes was poor observation, playing a role in 53% of urban crashes in 2006–2011 (figure 7.23). Next in importance was failure to giveway or stop (36% of urban crashes). Other prominent factors included alcohol, poor handling and speed ('too fast').

In the last decade, poor observation, alcohol, poor handling, speed and poor judgement have increased in importance as contributing factors to urban road crashes. Failure to giveway or stop has decreased in importance.

Figure 7.23
Top 10 Contributing Factors to Urban Road Injury Crashes
 New Plymouth District
 Five year periods to 2011



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
 Data in appendix table 7.19.

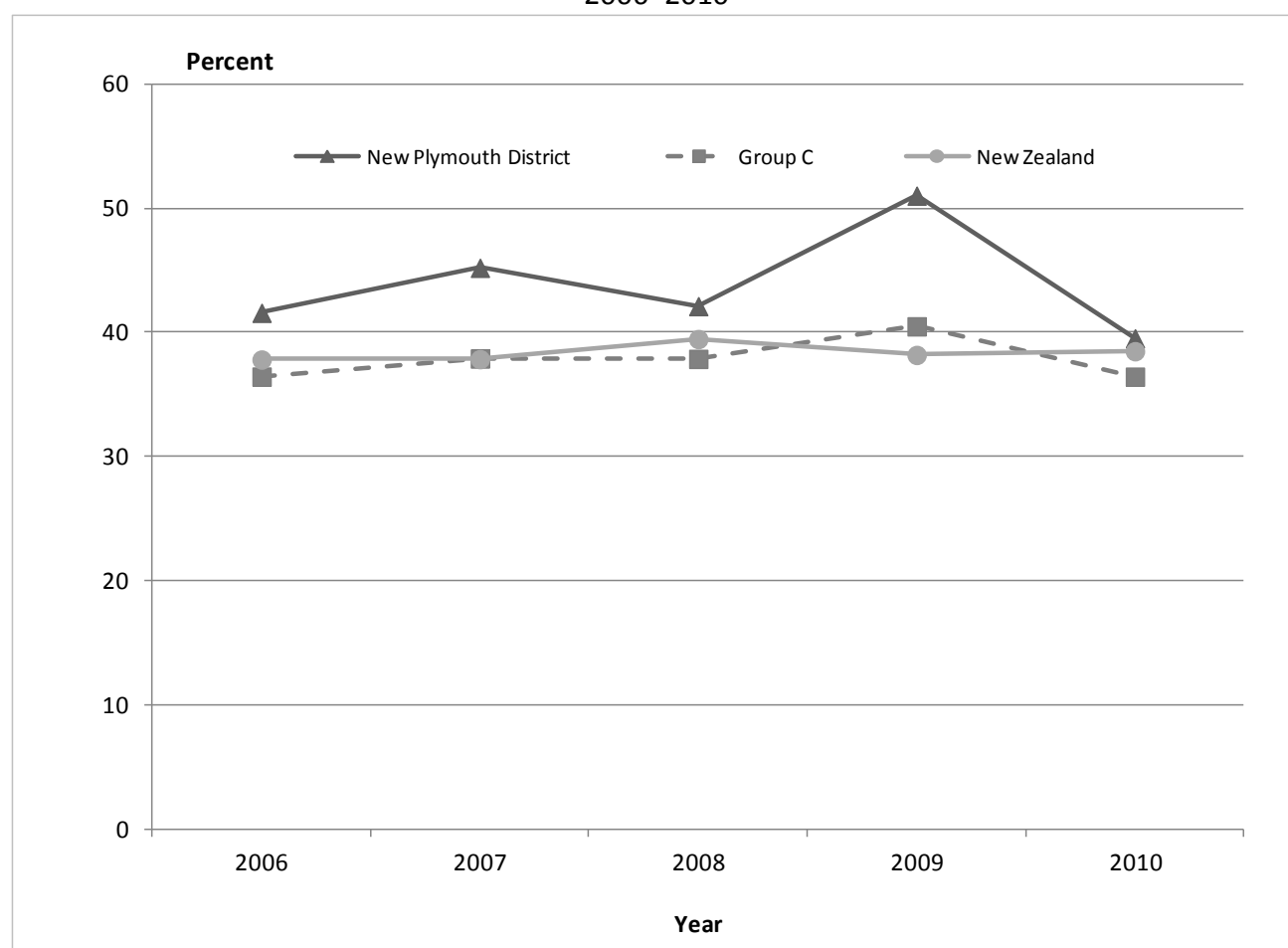
Note: Years are financial years 1 July to 31 June.
 Crashes = number of crash incidents.

Intersection crashes

In the previous five years, the proportion of injury road crashes occurring at intersections was slightly higher on New Plymouth District roads than on New Zealand roads as a whole (figure 7.24). It was also higher than on Group C roads. Group C is a selection of NZ provincial areas with population and road features similar to New Plymouth District's.

Figure 7.24

Injury Crashes Occurring At Intersections New Plymouth District, Group C* and New Zealand 2006–2010



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.

Data in appendix table 7.20.

Note: Years are financial years 1 July to 31 June.

Crashes = number of crash incidents.

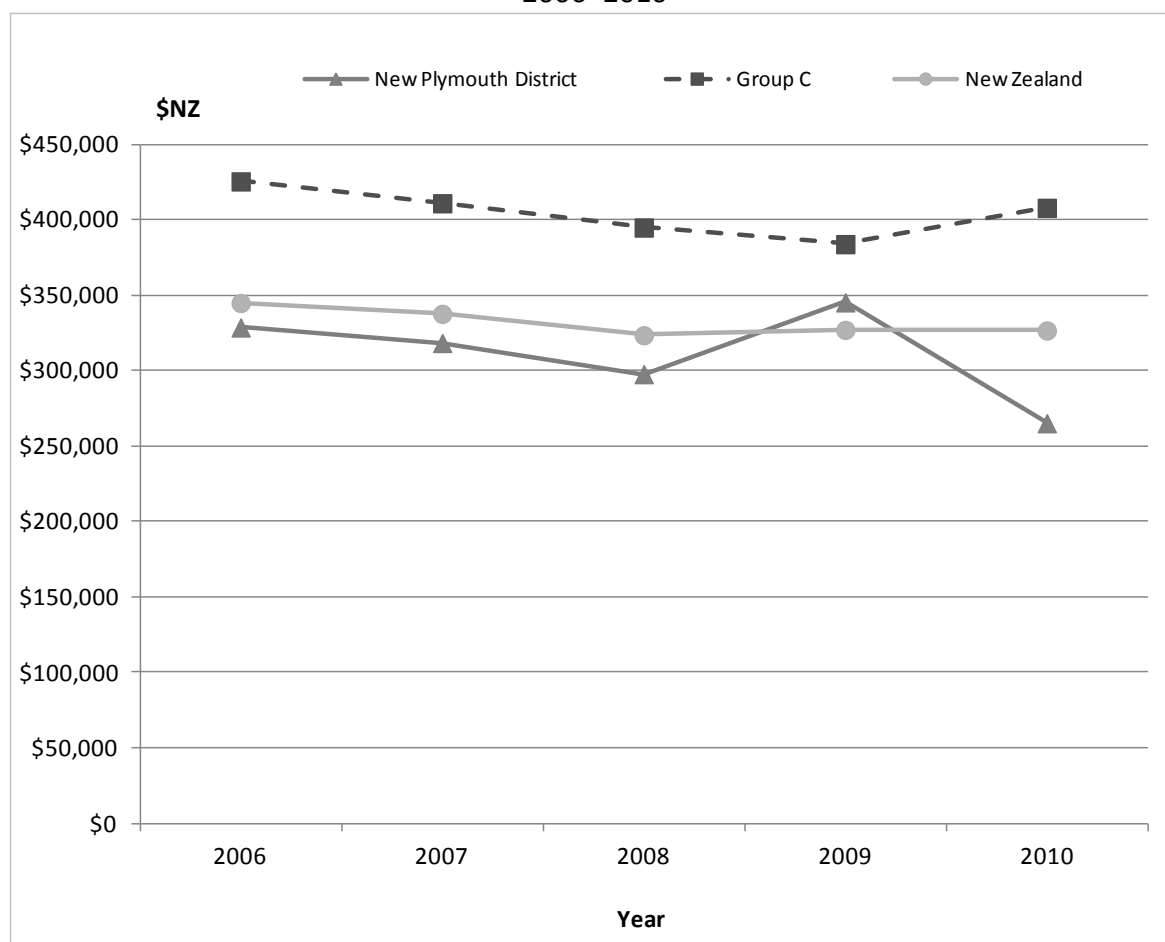
* Group C is a group of large NZ provincial towns and hinterland with populations of 35,000–75,000 and / or where rural crashes are less than 55 percent of all crashes in the area. Group C TLAs = New Plymouth District, Gisborne, Hastings, Kapiti Coast, Porirua, Rotorua, Timaru, Upper Hutt, Whanganui and Whangarei.

Social costs of injury crashes

In the five years 2006 to 2010 the average social cost of New Plymouth District injury road crashes was consistently lower than the Group C average and generally lower than the New Zealand average (figure 7.25). In 2010 for instance, each New Plymouth District injury road crash was estimated to have an average social cost of \$265,140. This compares to an average of \$407,854 for Group C crashes and \$326,568 for all New Zealand crashes.

Figure 7.25

Average Social Cost Per Injury Road Crash
New Plymouth District, Group C* and New Zealand
2006–2010



Sources: New Zealand Transport Agency 2010, unpublished data for 2010 supplied by New Zealand Transport Agency.
Data in appendix table 7.21.

Note: Years are calendar years 1 January to 31 December.

Crashes = number of crash incidents.

* Group C is a group of large NZ provincial towns and hinterland with populations of 35,000–75,000 and / or where rural crashes are less than 55 percent of all crashes in the area. Group C TLAs = New Plymouth District, Gisborne, Hastings, Kapiti Coast, Porirua, Rotorua, Timaru, Upper Hutt, Whanganui and Whangarei.

Road crash risk factors in Taranaki

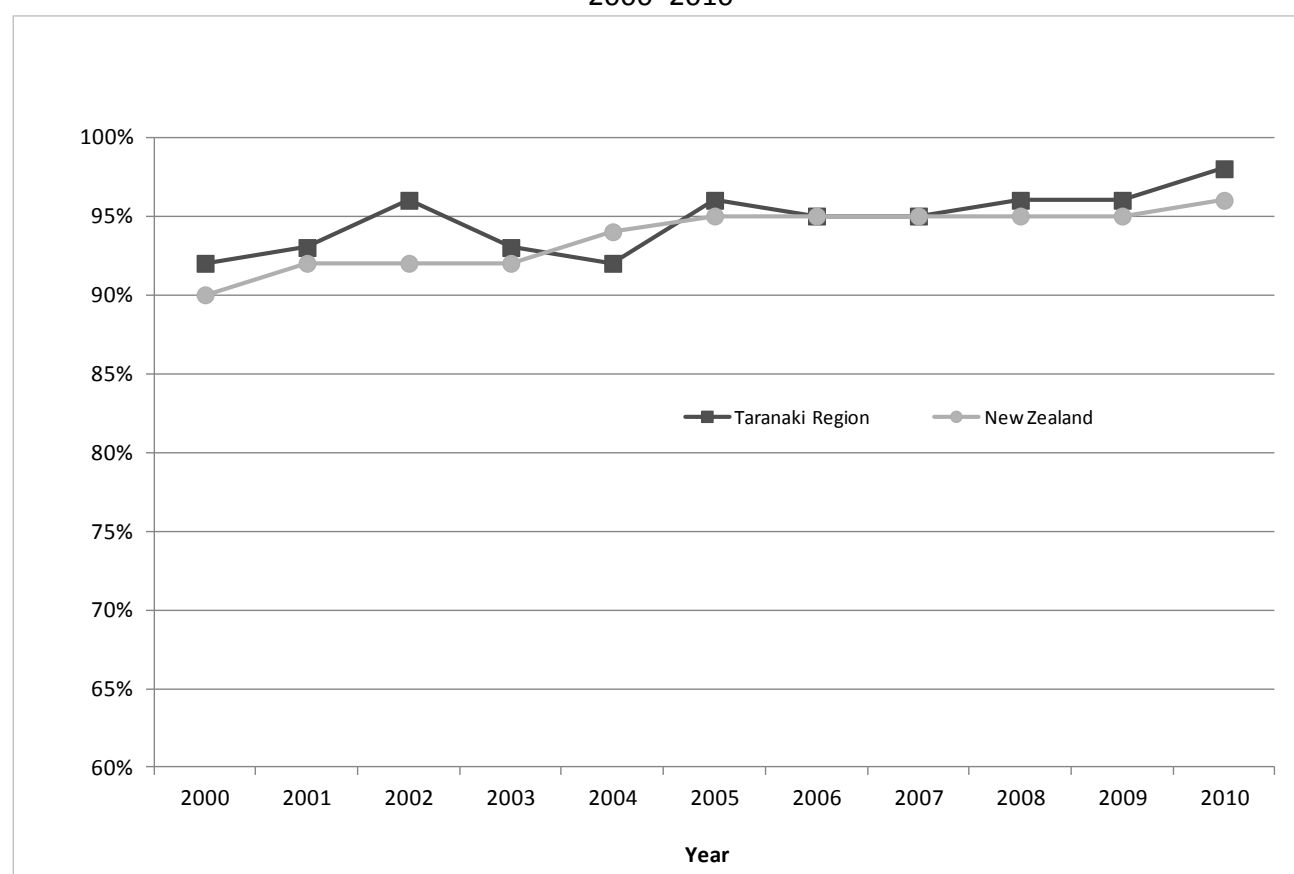
The next series of charts look at the larger Taranaki region rather than just the New Plymouth District.

Seatbelt use

Over the 11 years from 2000 to 2010 the proportion of Taranaki adults using seatbelts when in the front of vehicles has risen from 92 and 93% in 2000 and 2001 to 96 and 98% in 2009 and 2010. This increase is largely in keeping with adult front seatbelt wearing rates in New Zealand as a whole during this period (figure 7.26).

Figure 7.26

Front Seatbelt Wearing by Adults Aged 15+ – Rates (percent)
Taranaki Region and New Zealand
2000–2010



Source: Ministry of Transport annual surveys of restraint use (www.transport.govt.nz/research/safetybeltstatistics/).
Data in appendix table 7.22.

Note: Years are calendar years 1 January to 31 December.

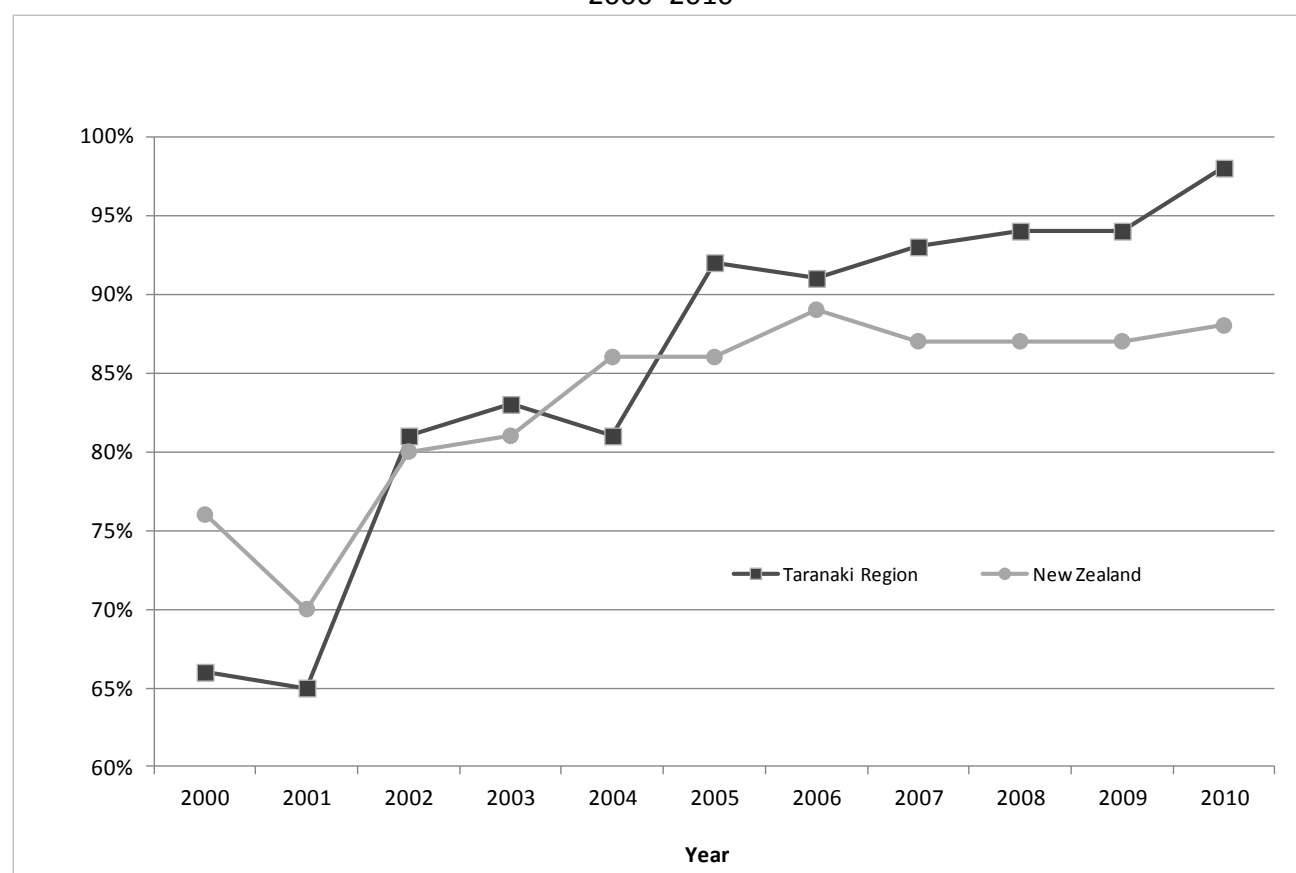
Front seatbelt wearing = seatbelt wearing by adults (aged 15+) in the front seat of cars (driver and passenger) on open and urban roads.

The proportion of Taranaki adults using seatbelts when travelling in the rear seat of vehicles rose markedly between 2000 and 2010, from a low of 65% in 2001 to a high of 98% in 2010 (figure 7.27).

From 2005 onwards Taranaki adult rear seatbelt wearing rates have been consistently higher than the New Zealand average.

Figure 7.27

Rear Seatbelt Wearing by Adults Aged 15+ – Rates (percent)
Taranaki Region and New Zealand
2000–2010



Source: Ministry of Transport annual surveys of restraint use (www.transport.govt.nz/research/safetybeltstatistics/).

Data in appendix table 7.22.

Note: Years are calendar years 1 January to 31 December.

Rear seatbelt wearing = seatbelt wearing by adults (aged 15+) in the left or right rear seat of cars travelling to or from the open road.

Child restraint use

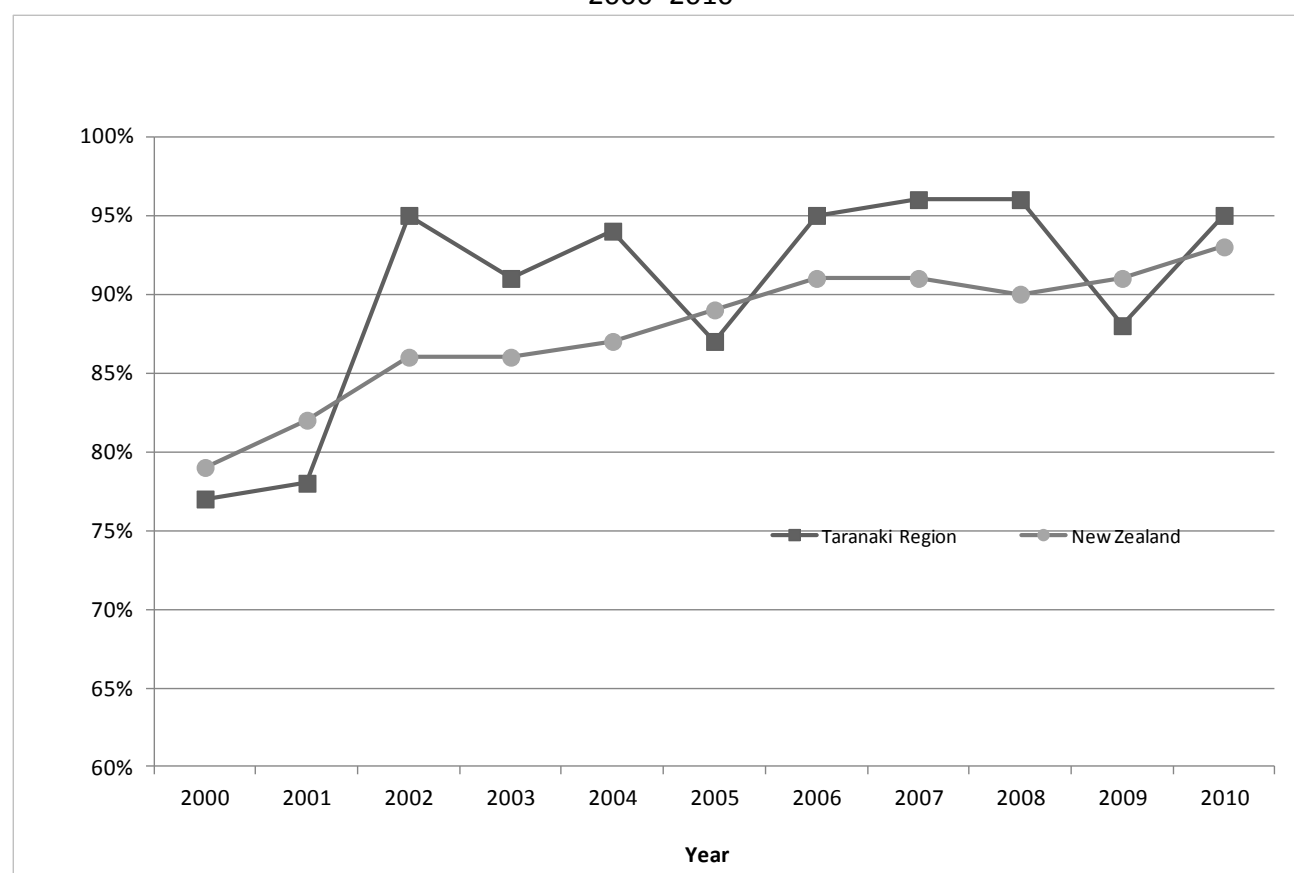
Rates of child restraint use (use of infant seats, child seats, booster seats or child harnesses) by Taranaki children aged 0–4 travelling in vehicles increased markedly between 2000 and 2002, from 77% to 95% (figure 7.28). Rates fluctuated in the years after this although they still remained higher than the New Zealand average in every year except 2005 and 2009.

Figure 7.28

Child Restraint Use by Children Aged 0–4 – Rates (percent)

Taranaki Region and New Zealand

2000–2010



Source: Ministry of Transport annual surveys of restraint use (www.transport.govt.nz/research/safetybeltstatistics/).

Data in appendix table 7.22.

Note: Years are calendar years 1 January to 31 December.

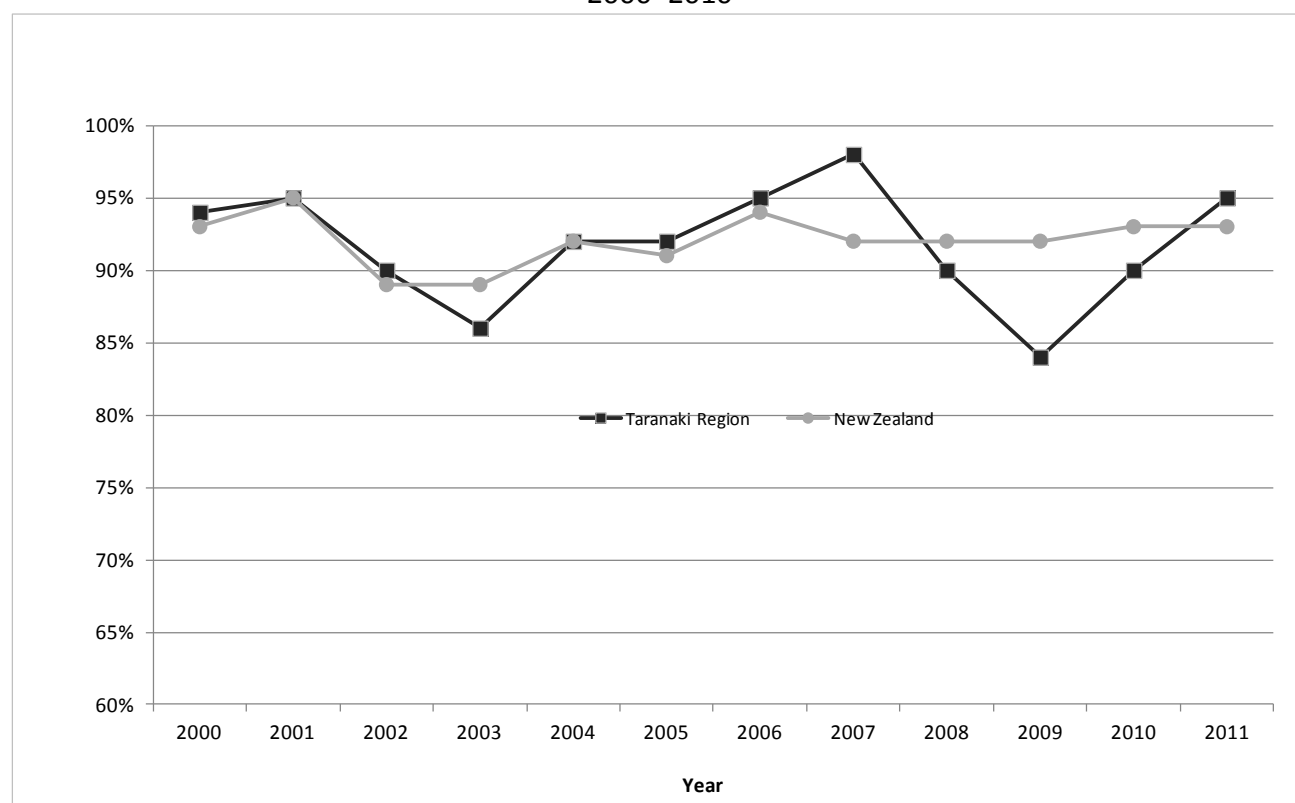
Child restraint use = child restraint use by children under 5 on urban roads.

Cycle helmet use

Taranaki's rates of cycle helmet use have fluctuated in the 11 years to 2011, falling to lows of 86% and 84% in 2003 and 2009 but rising to a high of 98% in 2007. Generally rates have aligned with the New Zealand average (figure 7.29).

Figure 7.29

Cycle Helmet Use – Rates (percent) Taranaki Region and New Zealand 2000–2010



Source: Ministry of Transport annual surveys of cycle helmet use (see www.transport.govt.nz/research/RoadSafetySurveys/).
Data in appendix table 7.23.

Note: Years are financial years 1 July to 31 June.

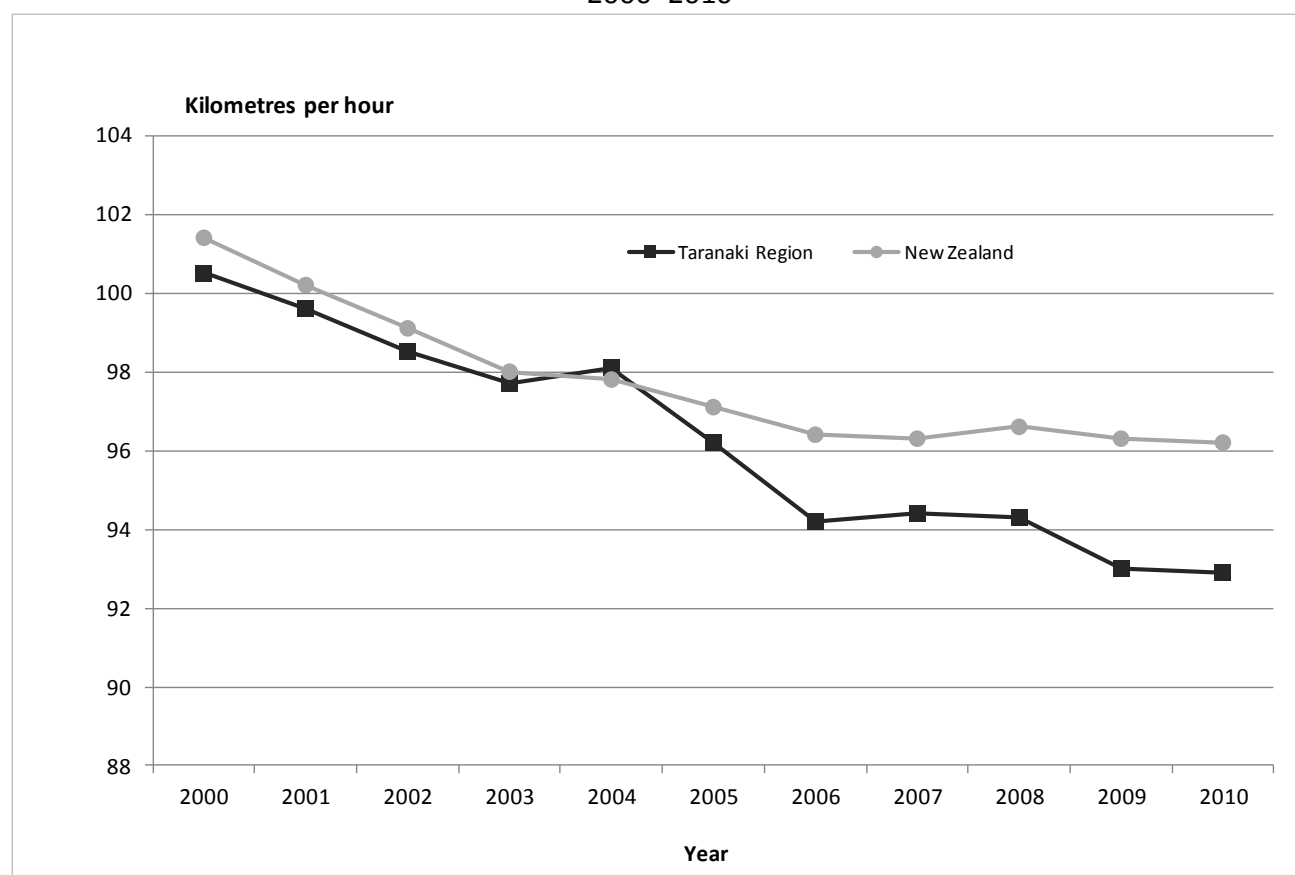
Cycle helmet use = use on weekdays by primary/intermediate, secondary school and adult cyclists.

Road speeds

Open road speeds of motorists on Taranaki's roads have steadily fallen in the last decade (figure 7.30). They have also decreased considerably more than the open road speeds observed in New Zealand as a whole.

Figure 7.30

Average Open Road Speeds Taranaki Region and New Zealand 2000–2010



Source: Ministry of Transport annual surveys of unimpeded vehicle speeds on open and urban roads (see www.transport.govt.nz/speed-index/).

Data in appendix table 7.24.

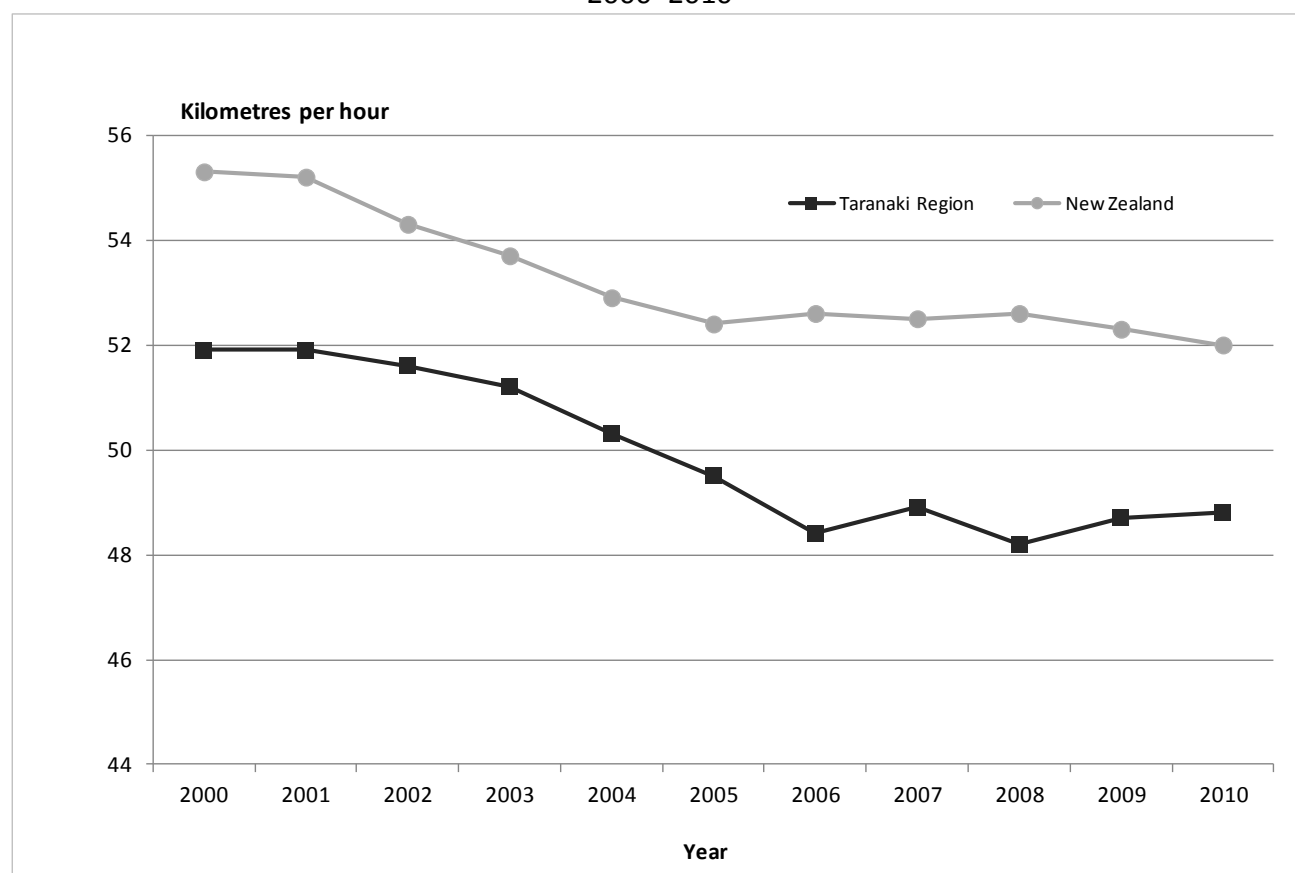
Note: Years are financial years 1 July to 31 June.

Open road = 100km/h speed limit.

Urban road speeds have also steadily declined in Taranaki over the last decade, from an average speed of 51.9 km/h in 2000 to an average speed of 48.8 km/h in 2010. Moreover, throughout the period the region's urban road speeds have consistently remained at least 2-3 km/h lower than the New Zealand average (figure 7.31).

Figure 7.31

Average Urban Road Speeds
Taranaki Region and New Zealand
2000–2010



Source: Ministry of Transport annual surveys of unimpeded vehicle speeds on open and urban roads (see www.transport.govt.nz/speed-index/).

Data in appendix table 7.24.

Note: Years are financial years 1 July to 31 June.

Urban road = 50km/h speed limit.

8

SUICIDE

Suicide statistics for New Plymouth District are compiled by the Ministry of Justice's Coronial Services Unit.

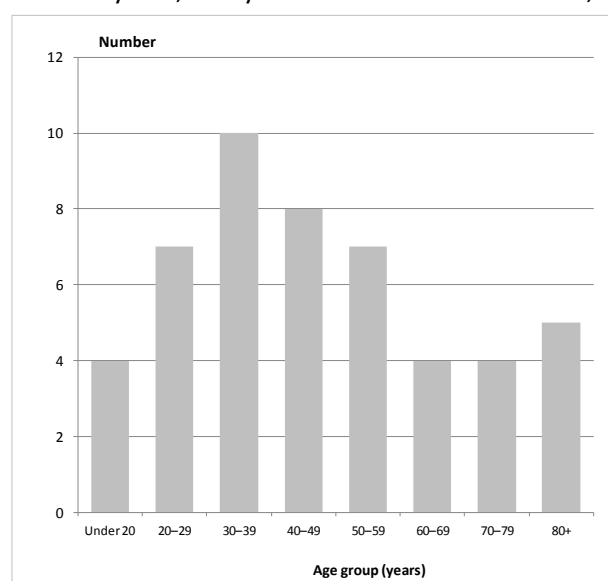
According to the coroner, in the three and a half years from July 2007 to December 2010, a total of 49 New Plymouth District people completed suicide. This is an average of 14 suicide deaths per year or approximately 1 suicide per month.

Forty-five of the 49 who completed suicide were male (92%). Four were female (8%).

Those who completed suicide were most commonly aged 30–39 (20%) or 40–49 (16%) although adults in all age groups were represented (figure 8.1).

Figure 8.1

Number of Deaths by Suicide
New Plymouth District, by age
Three and a half years, 1 July 2007 to 31 December 2010, combined



Source: Coronial Services Unit, Ministry of Justice.
Data in appendix table 8.1.

Suicide method

Hanging was the most common suicide method (figure 8.2). Next was shooting with a firearm. More than half (53%) of all suicides involved hanging and 18% involved some type of firearm.

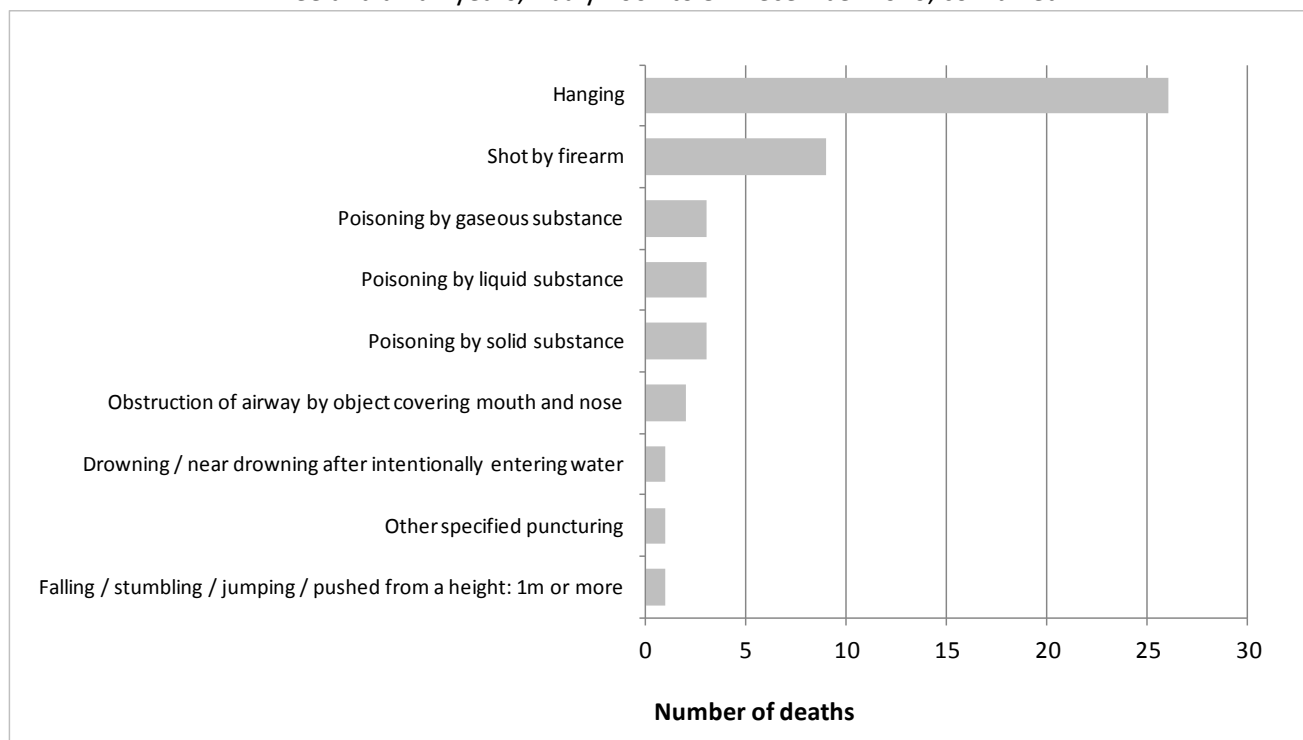
Featuring strongly, too, was exposure to poisonous substances, whether gas, liquid or solid. Suicides of this type were 18% of the total, comparable to firearms in significance.

Figure 8.2

Mechanism of Injury Resulting in Death by Suicide

New Plymouth District

Three and a half years, 1 July 2007 to 31 December 2010, combined



Source: Coronial Services Unit, Ministry of Justice.

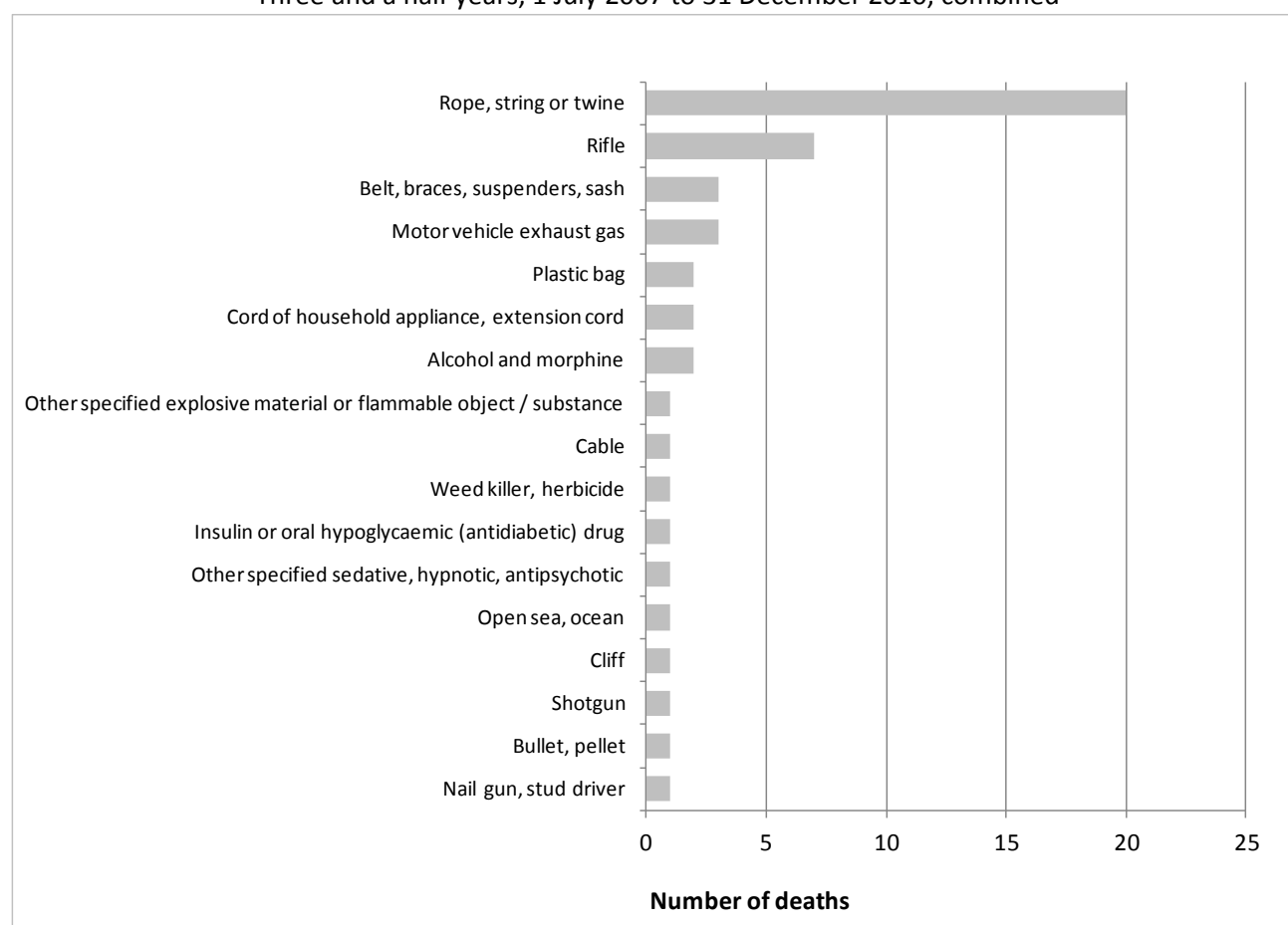
Objects or substances used

In keeping with the high proportion of suicides involving hanging, the most common object or substance used for suicide was 'rope, string or twine' (figure 8.3). The categories 'belts, braces, suspenders, sash', 'cord of household appliance, extension cord' and 'cable' are also likely in most cases to refer to suicide by hanging.

'Rifle' was the second most common object or substance used. The categories 'shotgun', 'bullet, pellet', and 'nail gun, stud driver' also refer to the use of some kind of firearm or shooting device.

Suicides involving exposure to poisonous gases, liquids or solids include use of the following types of substances: 'motor vehicle exhaust gases', 'alcohol and morphine', 'weed killer, herbicide', anti-diabetic drugs, and sedatives, hypnotics and antipsychotic drugs.

Figure 8.3
Object or Substance Producing Injury Resulting in Death by Suicide
 New Plymouth District
 Three and a half years, 1 July 2007 to 31 December 2010, combined



Source: Coronial Services Unit, Ministry of Justice.

As discussed earlier, the NPiS Trust has completed a detailed suicide prevention needs assessment for the Taranaki region. This contains valuable background statistics and a review of relevant scientific literature on suicide and self-harm (New Plymouth Injury Safe 2008). The report concluded that four groups have a high risk of suicide in Taranaki:

- young males, especially young Māori males
- older non-Māori males
- farmers
- mental health service consumers.

Young adult and adult females, especially those aged 15–24 and 25–44 were considered to have the highest risk of deliberate self-harm.

The report of the needs assessment can be downloaded from the New Plymouth Safe Community website.

9

DROWNING

Deaths from drowning

Water Safety New Zealand's Drownbase indicates there were 10 deaths from drowning in New Plymouth District from 2005 to 2010. This includes two drownings in 2006, four in 2007, one in 2008 and three in 2009.

Table 9.1

Number of drownings New Plymouth District 2005–2010

Year						Total	Average annual drowning deaths 2005-2010
2005	2006	2007	2008	2009	2010		
0	2	4	1	3	0	10	1.7

Source: Water Safety NZ Drownbase.
Figures are provisional.

Over the six years, the district's annual rate of drowning (2.4 per 100,000 residents per annum) was virtually identical to the total New Zealand rate (2.5 per 100,000 per annum).

Because of the small numbers it is not possible to analyse trends over the five-year period or calculate annual rates.

Hospitalisation for near drowning

In the five years from 2006 to 2010, a total of 9 New Plymouth residents were hospitalised as a result of accidental drowning and submersion (see appendix table 4.2).

Circumstances of drowning

Because the number of drownings in New Plymouth District is comparatively small, it is not possible to analyse underlying risk factors specific to the area. However, the data for New Zealand indicates that in general (Water Safety New Zealand n.d.):

- people who drown are mainly adults rather than children; school-age children make up only a small proportion of the drowning figures
- Maori and Pacific peoples are overrepresented in the drowning figures
- every year about three-quarters of drowning victims are male
- traditionally the summer months of January, February and December have the highest drowning deaths
- in 2010, the top New Zealand regions for drowning deaths were, in order, the South Island's West Coast, Northland, Tasman/Nelson, Waikato and Manawatu/Whanganui. Taranaki did not figure in the top 10 regions.
- about half of all drownings occur during recreational activity (swimming, boating, etc.), but another quarter are linked to road vehicle incidents, suicide or homicide.
- a third of all drownings occur in rivers and another 20% at beaches. Just 1% are in home pools. Another 1% are in public pools.

10

CRIMES AND PROTECTION ORDERS

Violent offences such as homicide, assault, sexual assault and aggravated robbery cause physical and psychological injury, not just to victims but also their families and other loved ones. Burglary, theft, property damage, and public disorder can also leave people feeling unsafe in the community, irrespective of any material losses.

Total offences

In the New Plymouth Police District in 2010 there were a total of 5,817 reported and recorded offences. Theft was the most common type of offence, followed by public order offences, and property damage and environmental pollution (table 10.1 overleaf). Together these three types of offences accounted for more than half of all recorded offences in the district.

Looking only at offences involving direct physical assault or injury to people (including common assault, serious physical assault, sexual assault and homicide), a total of 736 such offences were recorded in 2010.²⁷ This was 13% of all offences in New Plymouth District.

Compared to New Zealand as a whole, New Plymouth District had a lower proportion of theft offences, and burglary and breaking and entering offences but a higher proportion of public order offences, acts intending to cause injury and illicit drug offences.

Looked at over time on a population basis, recorded offences in general have declined in both New Plymouth District and New Zealand as a whole (figure 10.1, overleaf).²⁸ New Plymouth's annual offense rate has remained consistently below the New Zealand average, apart from in 2006–2008 when it rose to be almost the same as New Zealand's.

²⁷ This excludes offences involving abduction, harassment and other related offences against a person as these may not necessarily involve direct physical assault or injury. This and other similar categories of offending may become more relevant in future should emotional or psychological injury be given greater prominence in injury prevention frameworks.

²⁸ Changes in offending rates may reflect variations in the reporting of offences as well the incidence of offences.

Table 10.1

Main Types of Offences
New Plymouth Police Area and New Zealand
2010

Type of offence	New Plymouth		New Zealand	
	No.	Percent	No.	Percent
Theft and related offences	1,546	27	136,932	32
Public order offences	803	14	46,105	11
Property damage and environmental pollution	794	14	58,483	14
Acts intended to cause injury	687	12	44,515	10
Unlawful entry with intent/burglary, break and enter	562	10	59,323	14
Illicit drug offences	466	8	22,995	5
Offences against justice procedures, government security and government operations	346	6	19,083	4
Fraud, deception and related offences	198	3	9,726	2
Abduction, harassment and other related offences against a person	183	3	14,157	3
Prohibited and regulated weapons and explosives offences	125	2	7,074	2
Sexual assault and related offences	48	1	3,016	1
Robbery, extortion and related offences	26	0	2,641	1
Dangerous or negligent acts endangering persons	13	0	859	0
Homicide and related offences	1	0	97	0
Miscellaneous offences	19	0	1,339	0
Total	5,817	100	426,345	100

Source: Statistics New Zealand Table Builder, Police data.

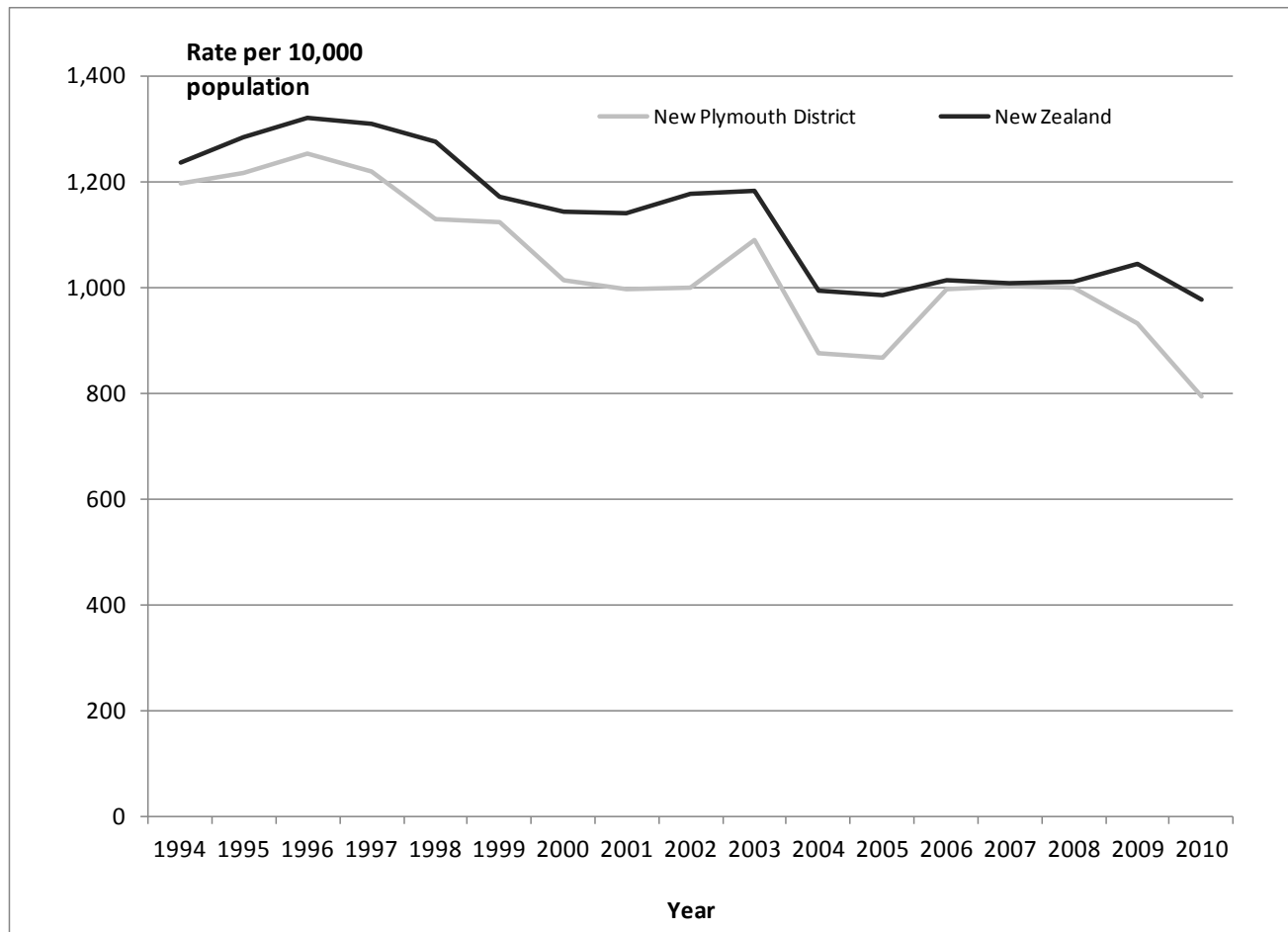
Data in appendix table 10.2.

Note: Years are calendar years 1 January to 31 December.

The categories police use to classify offences have changed since the 2006 New Plymouth injury prevention needs assessment.

Figure 10.1

Total Offences
New Plymouth Police Area and New Zealand
1994–2010



Source: Statistics New Zealand Table Builder, Police data.

Data in appendix table 10.1.

Note: Years are calendar years 1 January to 31 December.

These are crude population rates. They have not been adjusted to control for the slightly different age structures of the New Plymouth and New Zealand populations.

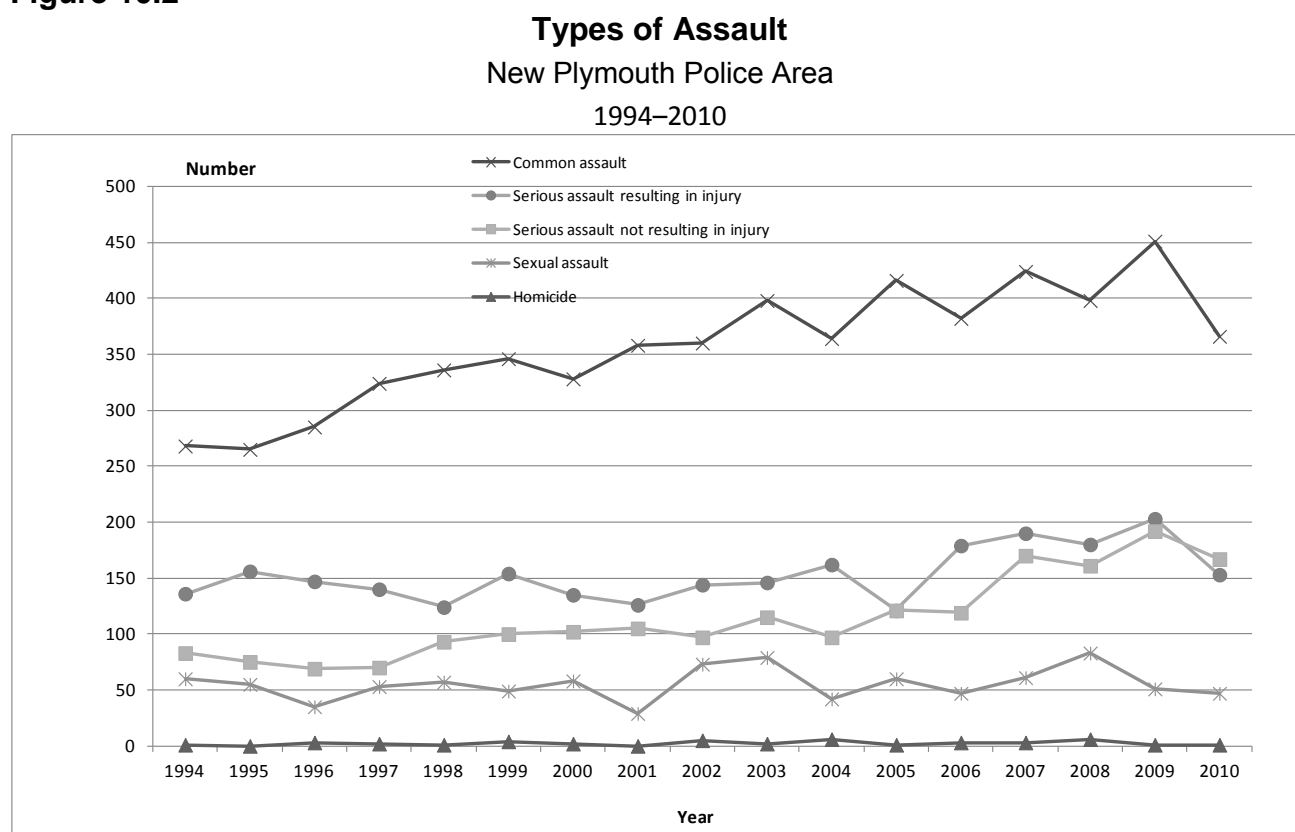
Purely in terms of numbers, from 1994 to 2010 the total volume of offences reported in New Plymouth District decreased by 29% (from 8,145 to 5,817). This is larger than the decrease for New Zealand as a whole (21%).

Assaults

Common assault is the most frequent type of violent offence in New Plymouth District. Next is serious assault (either resulting or not resulting in injury) followed by sexual assault. Homicides are rare. Common assaults are where an assault takes place but without an intention to cause injury. Serious assaults are assaults where there is an intention to injure, whether or not an injury is recorded.

From 1994–2010 the numbers of common and serious assaults increased in New Plymouth District (see figure 10.2). The numbers of sexual assaults and homicides fluctuated with no obvious upward or downward trend.

Figure 10.2



Source: Statistics New Zealand Table Builder, Police data.
Data in appendix table 10.3.

Note: Years are calendar years 1 January to 31 December.

Family violence offences

Offences recorded by the Police related to family violence include certain types of assault and sexual offences, offences related to the neglect / ill-treatment of people under care, and breaches of protection orders.

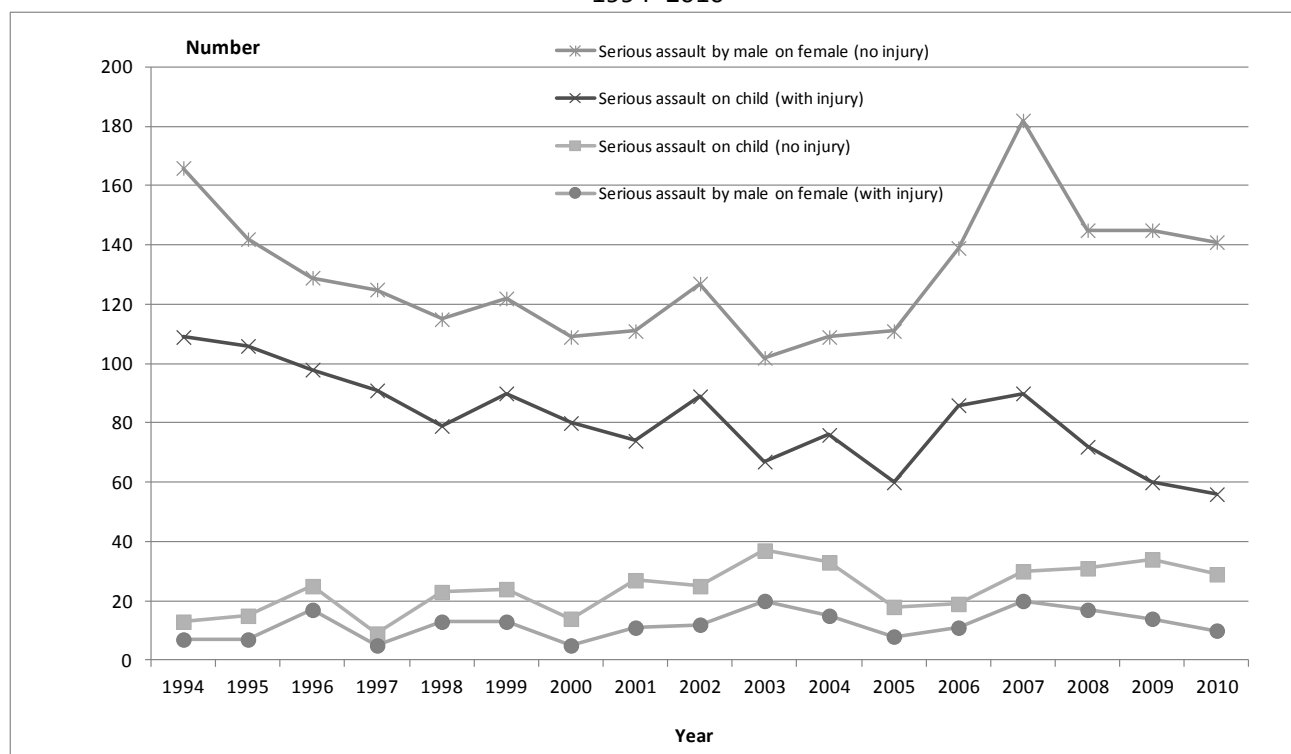
In New Plymouth Police District in 2010 there were 56 recorded serious assaults on children. There were also 10 serious assaults by males on females resulting in injury. In addition, there were 29 serious assaults on children not resulting in injury and 141 serious assaults by males on females not resulting in injury. It is likely that at least some of these more than 230 offences were related to family violence.

Since 1994, the numbers of serious assaults on children causing injury have gradually declined to about half (see figure 10.3 overleaf). The numbers of serious assaults on children not causing injury have increased slightly, as have the numbers of serious assaults by males on females causing injury.

Between 1994 and 2003 the numbers of serious assaults by males on females not causing injury generally decreased, but increased again after that.

Figure 10.3

Family Violence Involving Serious Assault Offences
New Plymouth Police Area
 1994–2010



Source: Statistics New Zealand Table Builder, Police data.

Data in appendix table 10.4.

Note: Years are calendar years 1 January to 31 December.

In 2010 New Plymouth District recorded a total of 106 offences relating to breaches of domestic violence orders, 50 common assaults (domestic) and 8 cases of neglect of children or adults under care (excluding patients and employees).

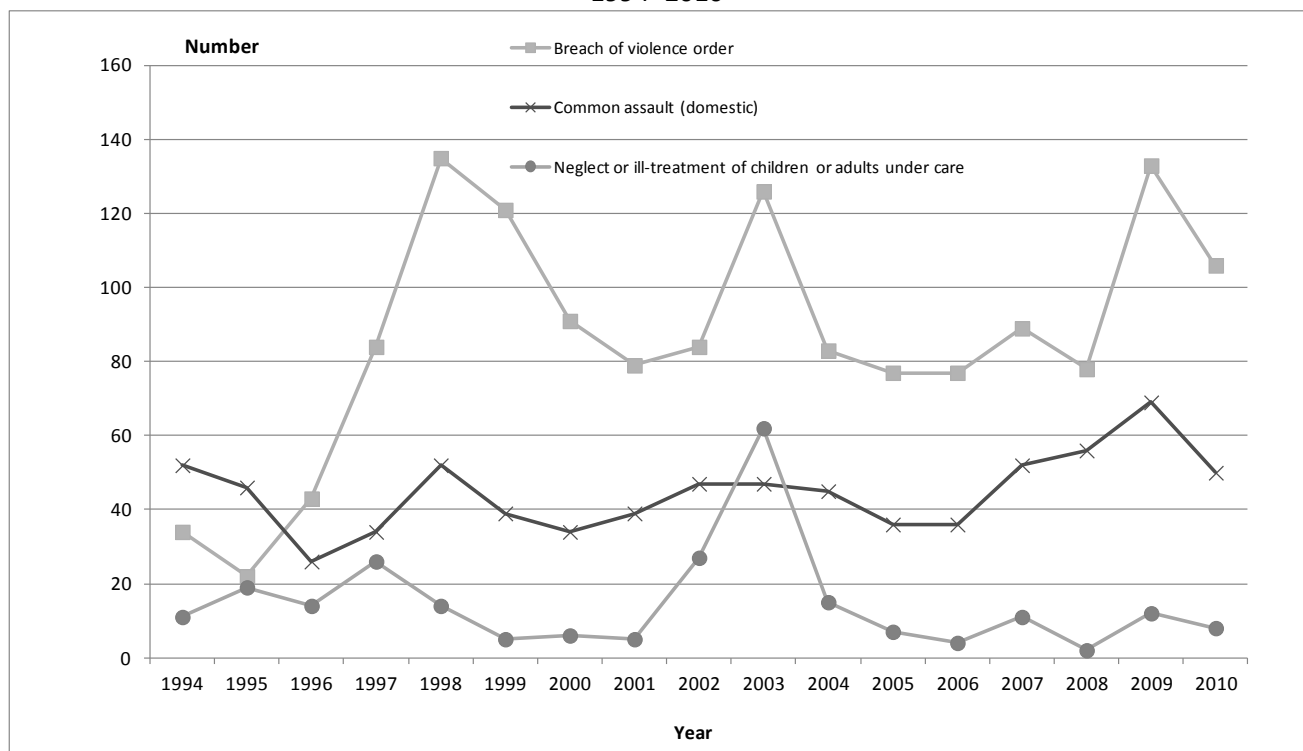
Since 1996, when the Domestic Violence Act replaced the Domestic Protection Act, the number of offences in the district relating to breaches of domestic violence orders have fluctuated somewhere between 80 and 130 offences per year.

Annual totals for common assault (domestic) also fluctuated over this period, peaking in 1998, 2003 and 2009 (figure 10.4).

Recorded cases of neglect of children or adults under care peaked in 2002 and 2003, falling to just a few cases per year after that (8 in 2010).

Figure 10.4

Other Family Violence Offences
New Plymouth Police Area
1994–2010



Source: Statistics New Zealand Table Builder, Police data. .
Data in appendix table 10.4.

Note: Years are calendar years 1 January to 31 December.

Apprehensions

As well as looking at the numbers of offences that take place, it is possible to examine the number of police apprehensions for these offences. An 'apprehension' means that an offender has been dealt with by the Police in some way, e.g. a warning, prosecution, or a referral to a youth justice family group conference or mental health service (Statistics New Zealand 2012). Information is available about the age, sex and ethnic group of people who are apprehended.

In the New Plymouth Police Area in 2010, there were 4,026 apprehensions altogether. The most common types of offences for which apprehensions were made were: theft and related offences; public order offences; and acts intending to cause injury (table 10.2 overleaf).

Compared with New Zealand as a whole, higher proportions of apprehensions in New Plymouth were for theft and related offences (22 percent vs. 17 percent). For most other types of offences, New Plymouth had a lower or fairly similar proportion of apprehensions.

In 2010, in the New Plymouth Police Area, over three-quarters (77 percent) of people apprehended for offences were male. This was similar to the proportion of male offenders in New Zealand (78 percent) (appendix table 10.5).

Forty-one percent of offenders apprehended in New Plymouth were aged 20 years or under, 29 percent were aged 21–30, and 30 percent were aged 31+. These proportions were similar to the New Zealand average (40 percent, 29 percent and 31 percent respectively) (appendix table 10.5).

In the same year in the local policing area, 42 percent of apprehended offenders were Māori, which was similar to the national figure (43 percent) (appendix table 10.6).

Table 10.2

Apprehensions by type of offence
New Plymouth Police Area and New Zealand
2010

Type of offence	New Plymouth		New Zealand	
	No.	Percent	No.	Percent
Theft and related offences	868	21.6	38,442	17.2
Public order offences	792	19.7	45,990	20.6
Acts intended to cause injury	589	14.6	38,943	17.4
Illicit drug offences	462	11.5	22,930	10.3
Offences against justice procedures, government security and government operations	335	8.3	17,709	7.9
Property damage and environmental pollution	310	7.7	19,879	8.9
Unlawful entry with intent/burglary, break and enter	183	4.5	11,820	5.3
Fraud, deception and related offences	151	3.8	5,783	2.6
Abduction, harassment and other related offences against a person	136	3.4	10,073	4.5
Prohibited and regulated weapons and explosives offences	132	3.3	6,865	3.1
Sexual assault and related offences	24	0.6	1,655	0.7
Robbery, extortion and related offences	20	0.5	1,588	0.7
Miscellaneous offences	14	0.3	1,018	0.5
Dangerous or negligent acts endangering persons	7	0.2	653	0.3
Homicide and related offences	3	0.1	103	0.0
Total	4,026	100.0	223,451	100.0

Source: Statistics New Zealand Table Builder, Police data.

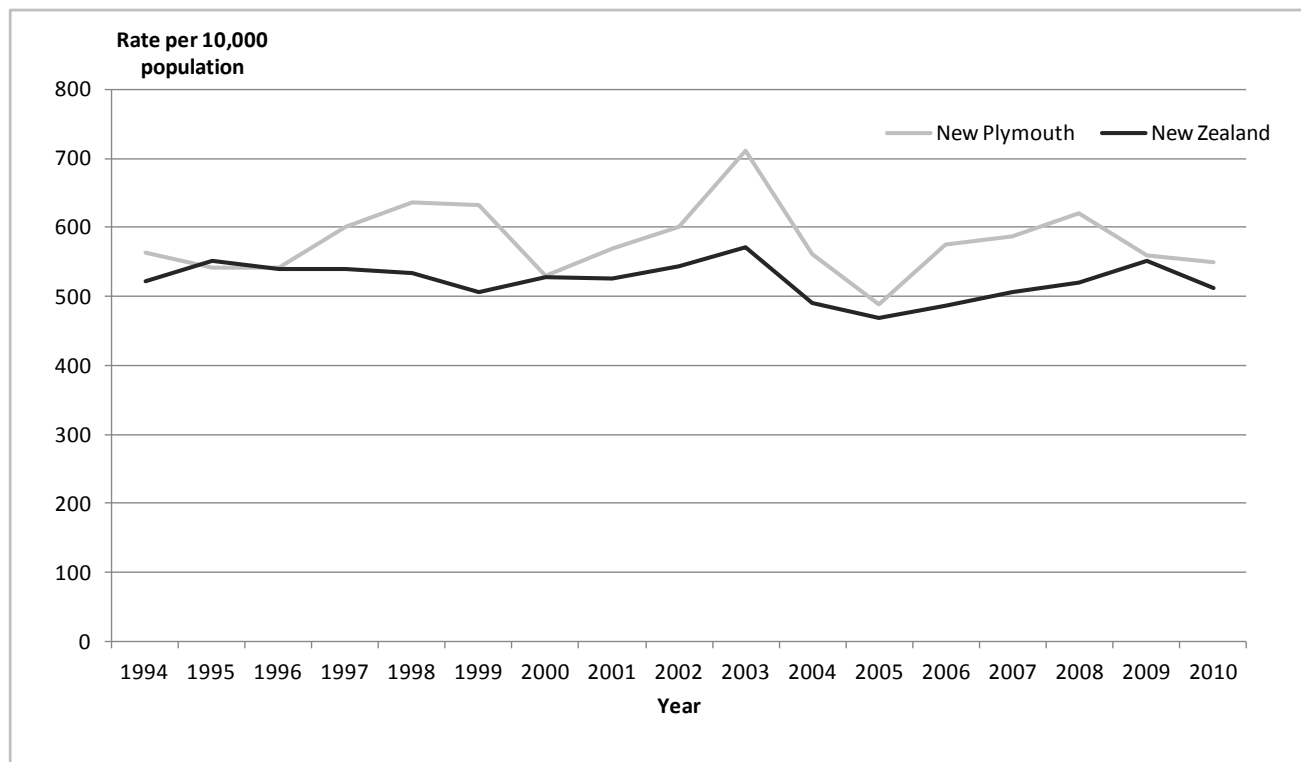
Note: Years are calendar years 1 January to 31 December.

For most of the period 1994–2010, the rates of apprehensions (per 10,000 population) for the New Plymouth Police Area were higher than for New Zealand as a whole. The exceptional years were 1995, 1996, 2000 and 2009, when local rates were similar to the national average (figure 10.5).

As already described above, rates of offences in New Plymouth were generally lower than the national rates. The opposite pattern for apprehensions suggests that a higher proportion of offenders may be apprehended in New Plymouth than nationally.

Figure 10.5

Apprehension rate
New Plymouth Police Area and New Zealand
1994–2010



Source: Statistics New Zealand Table Builder, Police data. .
Data in appendix table 10.7.

Note: Years are calendar years 1 January to 31 December.
Rates are crude rates i.e. they are not adjusted for the age of the population.

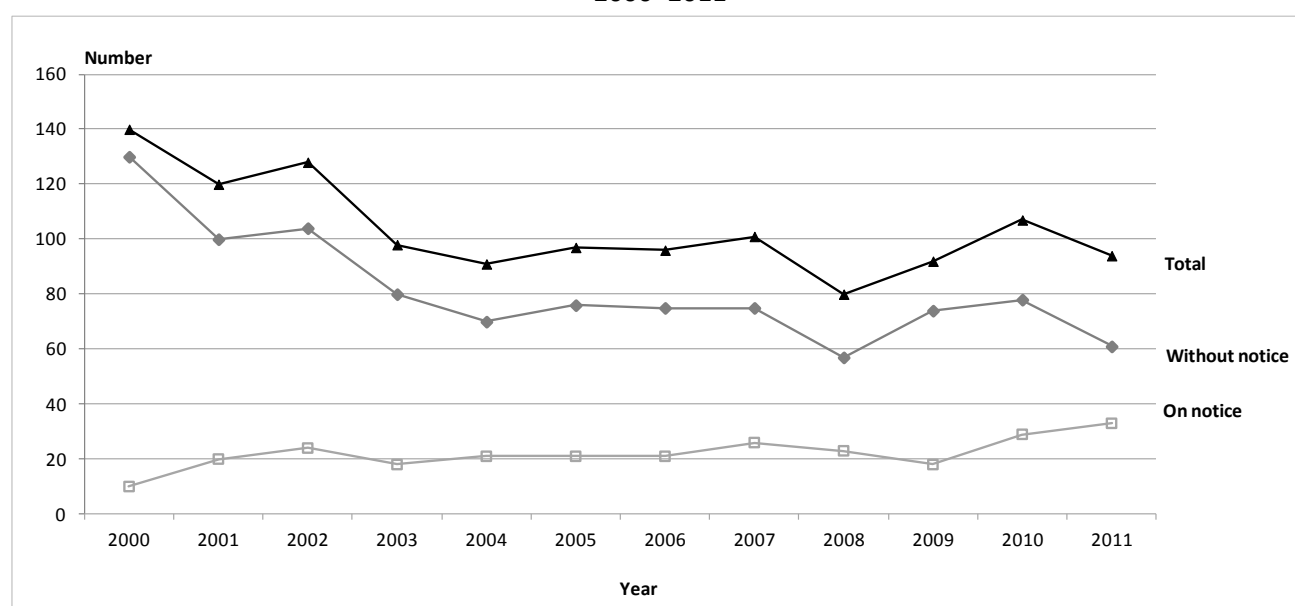
Protection orders

Individuals can apply for a protection order against someone they have a close personal relationship with (e.g. family member) or a person with whom they share accommodation. This is to address physical, psychological or sexual abuse they are experiencing from that person.

In the period 2000–2011, a total of 1,244 protection orders were filed in the New Plymouth Family Court. This was an average of 104 protection orders per year. Of these, 82% were ‘without notice’ (urgent) protection orders. The rest were ‘on notice’ (non-urgent) protection orders.

Looking at trends over time, during the 12-year period there has been a decline in the total annual number of protection orders. This decrease is due to the reduction of ‘without notice’ protection orders. In contrast, there has been a slight increase in ‘on notice’ protection orders (figure 10.6).

Figure 10.6
Protection Orders Filed in the New Plymouth Family Court
 By type of protection order
 2000–2011



Source: Data supplied by Ministry of Justice. Data in appendix table 10.8.

Note: Years are calendar years 1 January to 31 December

11

COMMUNITY CONSULTATION

This chapter reports the findings of the face-to-face interviews and email survey undertaken as part of the community consultation phase of the needs assessment. The main aim of the interviews and email survey was to gather feedback on what people considered to be:

- the main injury issues affecting the New Plymouth population
- ways to respond to these issues,
- the strengths and achievements of NPiS and the New Plymouth Safe Community initiative to date
- problem areas and ways the future work of NPiS could be improved.

In addition, comment was sought on the recently completed draft New Plymouth District Community Safety Strategy (New Plymouth District Council / New Plymouth injury Safe 2011).

As outlined earlier, the consultation gathered information from three different groups of people:

- 13 interviews with staff from local agencies, organisations and groups that run community injury prevention and safety programmes allied to NPiS ('stakeholders')²⁹
- 11 interviews with staff from local agencies and organisations that deal with injury and safety issues in New Plymouth District in a more general way, not necessarily as part of the NPiS network ('general / health interviewees')
- an email survey of 8 members of the NPiS Trust, the core group responsible for governing NPiS ('NPiS members').

²⁹ One interview included two people from the same organisation. Information from this interview has been counted as one stakeholder response.

For more detail on the research methods used, see the Introduction.

Combined consultation results for all three groups are presented below, organised into topics. The topics generally match those covered in the questions in the interview schedules and questionnaire. In the discussion below, for each topic, the particular group or groups answering questions relating to the topic are specified. The numbers of respondents making particular comments are shown in parentheses.

The topics are presented under five main headings:

- profile of community consultation participants
- injury and safety issues
- community injury prevention and safety programmes / activities
- NPiS network and New Plymouth Safe Community
- NPiS Trust.

Profile of community consultation participants

Table 11.1 overleaf lists the main organisations the community consultation participants belonged to, and the particular areas they worked in. Note that several individuals represented more than one agency or organisation.³⁰

³⁰ Two people who were both NPiS Trust members and stakeholders completed both a written questionnaire and a face-to-face interview.

Table 11.1**Main organisations community consultation participants belonged to³¹**

Stakeholders	General / health	NPiS Trust members
<u>Alcohol</u> <ul style="list-style-type: none"> Action on Alcohol Taranaki Liquor Licensing Agency, New Plymouth District Council 	<ul style="list-style-type: none"> ACC (general) ACC (Māori) General practitioner Midland Regional Health Network Tui Ora Ltd. (provider arm) Taranaki District Health Board (public health / planning and funding) Taranaki District Health Board (emergency department) Red Cross St. John Physiotherapy (general / sport) New Plymouth District Council (community development) 	<ul style="list-style-type: none"> Public health unit (health promotion) ACC (injury prevention) Midland Health Network (relationship management) New Plymouth District Council (councillor) New Plymouth District Council (community development) Tui Ora Ltd. (business development) Department of Labour (service management) NZ Fire Service
<u>Road safety</u> <ul style="list-style-type: none"> NZ Police Roadsafe Taranaki 		
<u>Crime prevention</u> <ul style="list-style-type: none"> NZ Police 		
<u>Family violence</u> <ul style="list-style-type: none"> Taranaki Safe Families Trust Tu Tama Wahine 		
<u>Civil defence and emergency planning</u> <ul style="list-style-type: none"> NZ Police 		
<u>Workplace safety</u> <ul style="list-style-type: none"> Be Safe Taranaki (BeST) Department of Labour 		
<u>Suicide / self harm prevention</u> <ul style="list-style-type: none"> Like Minds Taranaki Otago University Taranaki multi-level intervention suicide prevention project 		
<u>Preventing injuries among children</u> <ul style="list-style-type: none"> Kidsafe Taranaki 		
<u>Preventing injuries among older people</u> <ul style="list-style-type: none"> Taranaki District Health Board (planning and funding) 		

Additional groups the participants were connected to (not already mentioned above) include:

- General Practice Network
- (Taranaki Regional) Suicide Prevention Group
- Mental Health DHB Integrated Care – Primary and Secondary
- Central Taranaki Safe Community Trust

³¹ See the list of consultation participants at the end of this report for further detail.

- Public Health injury prevention programme
- Public Health alcohol harm reduction programme
- Roadsafes Taranaki
- Police Liaison working party
- New Plymouth District Alcohol Strategy
- Māori Health Providers
- Iwi
- National Hauora Coalition
- Ministry of Social Development
- ALAC
- Te Puni Kōkiri
- NZSIM
- Taranaki Construction Safety Group
- Taranaki Road Safety Action Planning Group
- Taranaki Regional Falls Prevention Group
- New Plymouth Positive Ageing Network
- Taranaki Motorcycle Safety Group
- Regional Water Safety Planning Group.

Injury and safety issues

The 11 general / health interviewees were asked if, in their experience, the patterns of injury or safety issues in New Plymouth District had changed in the last 10 years or so, and in what ways. For any changes identified, they were prompted for further information on the:

- types of injury or safety issues
- severity of injury or safety issues
- groups of people experiencing injury or safety issues
- places where injuries or safety issues occur
- causes of injury or safety issues.

In a later question the same group of interviewees were also asked if there was anything else that should or could be done to prevent injuries or safety threats to people in the district, with similar

prompts to get more details. Responses to each of the questions are summarised below in Table 11.2.³²

Table 11.2

Perceived patterns of injury and safety issues in New Plymouth District, and suggested solutions

Focus	Perceived changes in injury and safety patterns	Anything else that could be done?
General / all injuries	<ul style="list-style-type: none"> • There had been a reduction in the proportion of our work that is injury related • There has been a decrease in the severity of injuries 	<ul style="list-style-type: none"> • Education / first aid courses can limit the severity of outcomes • More programmes through NPiS • Need to have a 'warrant of fitness' for ourselves (to determine how to prevent injuries for individuals) • Improvements in the environment • Improve values and personal responsibility • There needs to be a balance between levels of risk and learning to be safe – don't want to stifle all risk-taking e.g. going up the mountain and into the sea, but could educate people more about learning to be safe • Can go overboard with making environment safe e.g. fencing everything off, but if people can't see that something's dangerous, it's their problem, or if they can see the danger but decide to go ahead anyway, you can't stop them
Unintentional injuries	<ul style="list-style-type: none"> • Reduced 	<ul style="list-style-type: none"> • Are people being as careful as they could be?
Alcohol and drugs	<ul style="list-style-type: none"> • Increase in importance of alcohol-related injuries (falls, motor vehicle crashes, assaults) • Decrease in number of alcohol-related injuries • Alcohol and P (methamphetamine) are now the drugs of choice, with many people also using cannabis on a regular basis. Injured people on P are difficult to deal with as they can be unreasonable and unpredictable 	<ul style="list-style-type: none"> • Reduce alcohol binge-drinking by young people – need group like NPiS, mortality / morbidity meetings to brainstorm new ideas about how to do this • Need to improve attitudes

³² This question was asked after questions about people's knowledge of what was already being done locally to address injury and safety issues (see section below for the results of these questions). Each dot-point represents a single comment, unless otherwise specified.

Table 11.2 (continued)

Focus	Perceived changes in injury and safety patterns	Anything else that could be done?
Alcohol and drugs (continued)	<ul style="list-style-type: none"> Now there is sometimes a suspicion that P is involved in some of the injuries we see (e.g. burns) 	
Road safety	<ul style="list-style-type: none"> Decrease in number of motor vehicle crash injuries (including reduction in those related to texting / cell phone use, improved driver behaviour) Increase in severity of motor vehicle crash injuries (e.g. because of more powerful cars, head and spinal injuries) Decrease in severity of motor vehicle crash injuries Still young males at risk, using hotted-up cars, drugs, mobile phones Alcohol often involved in older people injured 	<ul style="list-style-type: none"> Increase use of technology e.g. disabling devices for cars of recidivist drink-drivers Legislation Motorcyclists and cyclists need to wear the proper gear, and this needs to be affordable People need to be more aware about what they are doing when driving and adopt values about this e.g. know the reasons for, and obey 40km speed limits near schools Continue to use car seats for children Need a safer environment for non-motor transport – this could be achieved through a number of measures such as increased motorist awareness, education of children cyclists, environmental / urban design
Assaults	<ul style="list-style-type: none"> Reduced An increase in injuries due to fights 	<ul style="list-style-type: none"> Individuals need to have different values
Family violence	<ul style="list-style-type: none"> Is one of the four most common types of injuries we work with, especially child abuse Is a hidden thing – underestimated and not visible. May manifest in a chronic way with various health problems and then realise later what the cause was e.g. when a marriage breaks up. 	–
Workplace	<ul style="list-style-type: none"> Labourers and forestry workers, i.e. in highly labour-intensive jobs get a lot of back injuries from lifting Construction / building workers prone to injuries People have blasé attitude to workplace safety There is now an aging workforce who are more vulnerable to work (and non-work) injuries. When combined with recent immigration, this can become more of a problem as these people may not be eligible for certain types of support 	<ul style="list-style-type: none"> More workplace programmes (2) Need more workplace injury prevention programmes for small workplaces Need workplace programmes for sedentary computer workers – they get occupational overuse syndrome (OOS), fatigue and poor posture which can be associated with long-standing / chronic and severe conditions Apprentice and workplace challenges are good
Sports / recreation	<ul style="list-style-type: none"> An increase in recreational motorcycling and motocross injuries One of the most common types of injuries we see now, especially rugby There are more things to fall off now, like ripsticks and skateboards etc. 	<ul style="list-style-type: none"> Need to wear the right gear e.g. mouthguards, headgear; and make environment safer e.g. pads around goal posts

Table 11.2 (continued)

Focus	Perceived changes in injury and safety patterns	Anything else that could be done?
Sports / recreation (continued)	<ul style="list-style-type: none"> An increase in injuries among over-zealous middle-aged people skateboarding, surfing, going to gyms etc. Men who tend to make risky decisions in competitive sports because of macho, male chauvinist attitude New programmes designed to get people active (e.g. to increase walking and cycling) could lead to more injuries 	
Home	<ul style="list-style-type: none"> DIY lifestyle still prominent and easier to identify these injuries now 	<ul style="list-style-type: none"> Increase injury prevention programmes related to home injuries Falls programmes
Rural / farms	<ul style="list-style-type: none"> There are still farmers who are unwilling to embrace a safety culture While farmers are taking safety more seriously, farmhands are less aware of the consequences and are commonly injured 	<ul style="list-style-type: none"> Increase rural injury prevention programmes Legislation for wearing helmets and rollbars on ATVs Keep an emphasis on farm helmets
Children / young people	<ul style="list-style-type: none"> There has been an improvement in the awareness of injury prevention among children doing sports and at school (e.g. sports coaches don't push them so much) – they are vulnerable to injury Children among groups most commonly seen for injuries There are still young risk takers 	<ul style="list-style-type: none"> It is up to families to teach children From primary school, students should do 15 minutes exercise per day and receive education about how to move to avoid injuries Sports coaches e.g. gymnastics should be educated (e.g. half-day courses)
Middle-aged people	<ul style="list-style-type: none"> An increase in middle-aged men falling off skateboards and surfboards 	<ul style="list-style-type: none"> Injury prevention programmes for middle-aged people (there are already programmes for young and older people)
Older people	<ul style="list-style-type: none"> Increase in falls because living in own home in a frail state for longer now, instead of in residential care Increase in falls A decrease in severity of injuries An improvement in the environment for elderly people e.g. seats provided on the coastal walkway 	<ul style="list-style-type: none"> Improve access to people's homes Expand falls prevention programmes again (some ACC funding withdrawn) Increase use of technology e.g. walking aids Programmes like Tai Chi and gyms need to be accessible and people should be able to try them out easily (without having to commit themselves to long-term use)
Māori	<ul style="list-style-type: none"> There are still inequalities between Māori and non-Māori 	<ul style="list-style-type: none"> Need to build community networks and support for Māori in a healthy way – strengthen Māori communities Improve Housing NZ homes that have safety risks
Injury prevention awareness	<ul style="list-style-type: none"> The public is more interested and make more enquiries GPs now are more aware of how to prevent injuries 	–

Table 11.2 (continued)

Focus	Perceived changes in injury and safety patterns	Anything else that could be done?
Injury prevention awareness (continued)	<ul style="list-style-type: none"> The thinking about safety has now broadened e.g. now includes how safe people feel There has been an increase in the awareness of injury prevention e.g. among older people – get a lot of feedback from the community about it There has been increase in awareness 	
Other	<p><u>Obesity</u> Increase in injuries among obese people who are more vulnerable to injury and recover less well e.g. because have Type II diabetes</p> <p><u>Self-management</u> People are less self-reliant now about managing their own injuries – partly because ACC has subsidised medical treatment</p> <p><u>NPDC</u> The District Council's involvement is more obvious now</p> <p><u>Public areas</u> Public areas are safer now</p> <p><u>Access to treatment</u> Access to treatment for injuries is affected by geographical and financial barriers</p>	<p><u>Crime</u> Improve certain areas of New Plymouth e.g. Pukekura Park where people don't feel safe at night and places in town where tourists' cars get broken into – but it is difficult to know how much we should do with limited resources</p> <p><u>Hospital patients</u> Injury prevention programmes for people already in hospital with injuries</p>

Community injury prevention and safety programmes / activities

The focus of this section is individual community organisations and groups, and their injury prevention and community safety programmes and activities.

Awareness of injury prevention / community safety programmes and activities

As might be expected, as the consultation was initiated by NPiS, the general / health interviewees most commonly said 'NPiS' when asked to name local injury prevention or community safety programmes and activities (7 of the 11 interviewees). A range of other programmes and activities were also listed:

- Kidsafe (3 interviewees)
- public health unit (2)
- New Plymouth District Council (2)
- ACC (e.g. non-work resources in workplaces; road, home and child safety programmes) (2)
- Be Safe Taranaki Centre (2)

- workplace programmes (at workplaces) (2)
- accreditation programmes (1)
- hospital programmes for the elderly (1)
- Tai Chi (1)
- move it / lose it classes for the elderly (1)
- child and youth mortality / morbidity meetings (1)
- injury prevention in general practice (1)
- publicity on commercial radio, billboards, Midweek newspaper, schools, workplace (1)
- Toolbox group (industrial health and safety demonstrations (1)
- Safer Families (1)
- injury strategies (1)
- WHO Safe Community (1)
- paracetamol poisoning project (1)
- Māori falls programmes (1)
- Māori children programme (1)
- Breastfeeding Week (1)
- Child Week (1)
- SIDS programme (1)
- road safety programmes (1).

Effectiveness of programmes / activities

The 11 general / health interviewees were asked if they had any views about how effective the above local community injury prevention or community safety programmes or activities were. Seven thought they were effective, in the following ways (each comment was made by one person):

- Māori programmes are working effectively by engaging the community on marae and in low socio-economic areas (non-Māori campaigns do not work with Māori)
- kaumātua are talking about and participating in the falls prevention programme
- there has been an increased awareness of issues, with good community feedback.
- we have a framework / strategy which is evidence-based with evaluations of specific programmes, regularly monitored
- NPiS is proactive, 'raises flags' and works well in network groups to help find solutions
- programmes like Tai Chi and knowing how to lift safely have been effective
- police statistics have shown an improvement

- people tend to feel safer in the CBD e.g. from Mellow Yellow campaign and newspaper articles
- some [programmes and activities] would have to be effective
- both local and national programmes / activities are effective because injury is now a smaller proportion of our workload.

Two other interviewees thought that the programmes / activities worked in some ways, but perhaps not in other ways. For example, one interviewee thought that messages get through only very gradually to change social acceptance of certain behaviours. For example, it is now much less acceptable to drink and drive. But maybe the messages are speaking to just 'the great middle class'. This interviewee was also unsure if one-off campaigns work in the short term (e.g. 'Family Violence is not OK') – and queried if these 'save anyone in real life'.

Another interviewee thought that messages are 'to some extent preaching to the converted in terms of listening.' This interviewee was not sure the messages get through to those who are vulnerable through socio-economic disadvantage; or to those who do not want to listen like some farmers and some of the 'more spirited and stropky' self-employed people who think it 'won't happen to them'. On the other hand this interviewee thought that the 'collective efforts' have been successful in fostering a perception that New Plymouth is a safe and desirable place to live.

Two further interviewees were unsure if the programmes / activities were effective: one because she did not know if the statistics supported the effectiveness of the programmes; the other because she thought it is not possible to reduce risk – people are always going to injure themselves.

Safe Community programmes / activities run by stakeholders

Turning now to the group of stakeholders who were interviewed for the needs assessment, 10 said the agencies they worked for had run programmes or activities that contributed to New Plymouth Safe Community (see table 11.3 below).

Table 11.3

Safe Community programme / activities run by community consultation stakeholders By safety focus, target groups and sites

Injury prevention/ safety focus	Target groups	Common sites where injuries occur
Alcohol-related agencies Action on Alcohol Taranaki Liquor Licensing NPDC	Families & youth Licensees/ employees & contractors re not to sell to minors	'Everywhere' e.g. on and in sports venues, streets, bars, cars, roads and private homes
Workplaces BeST Dept. of Labour	Employers, employees, contractors 'Big 4' = construction, manufacturing, fishing & forestry	Workplaces – construction sites Farms – quad bike users
Children's injuries KidSafe Trust (falls & poisonings)	5 year-olds and their parents/ carers	Settings focus – homes, future focus rural family homes

Table 11.3 (continued)

Injury prevention/ safety focus	Target groups	Common sites where injuries occur
Self-harm /suicide Prevention Like Minds Taranaki Otago University Suicide Research project	All mental health patients at risk of suicide / older men & middle-aged farmers – most at risk in Taranaki High risk groups nationally – youth, males, low SES Maori	Everywhere
Family Violence Tu Tama Wahine / Taranaki safe Families Trust NZ Police Safe Families Trust	Women mainly Everyone a potential victim or perpetrator	Home, parties – alcohol & drugs commonly involved Everywhere
Older people TDHB older people's portfolio	Older people including kaumatua MoH target group 70+	Private homes & rest homes
Road safety NZ Police Road Safety Coordinator	Road users – boy racers, 35-45 year-olds involved in most road crashes Schools, youth, parents of youth, motor cyclists, older people, general public	Roads

Most effective programmes and improvements

Stakeholders were also asked about which of their Safe Community programmes or related activities were most effective and why, as well as possible ways to improve their programmes / activities (table 11.4).

Table 11.4

Stakeholder views on their most effective Safe Community programmes / activities and possible improvements

By safety focus

Agencies' focus	Most effective programmes	Possible ways to improve programmes
Alcohol-related agencies Action on Alcohol Taranaki Liquor Licensing NPDC NZ Police	NPDC Alcohol Strategy – achieved high level of collaborative agencies engagement – a few who initially signed up to strategy non-contributors Drink Safe workshops – 100-200 turn up to these free annual workshops ThinkSmart sports club programme Mellow Yellow (also see crime prevention)	Work to strengthen / formalise relationships with non-contributing agencies who initially 'signed up' to strategy but don't see this as their core business Run more frequent workshops / ensure liquor licensing self-funding (current bill in second reading)

Table 11.4 (continued)

Agencies' focus	Most effective programmes	Possible ways to improve programmes
Workplaces BeST	Training centre work area specific training programmes in purpose built centre – high level of engagement – on neutral territory where participants can learn & network freely	Want to reach a broader range of workplaces including farms
Dept. of Labour	Trade Apprentices Challenge Award (an award winner) – collaborative initiative – now being rolled out across the country	Biggest on-going challenge is to get disinterested non-compliers interested – 'much is preaching to the converted'
Children's injuries KidSafe Trust (falls & poisonings)	Children's falls prevention programme – evaluated & shown to be effective. Success led to ACC funding in other parts of NZ – very process focused with built in evaluation component	Requires secure funding stream – current political environment has led to reduced commitment to health promotion type activities, has had considerable deleterious impact on work Depleted workforce another consequence- undermined efforts to reach 'hard to reach' groups
Family Violence Tu Tama Wahine / Taranaki safe Families Trust NZ Police Safe Families Trust	Children's group work Safety programmes with clear safety plans to get out of violent situations Multi-agency approach to wrap around services around victims and perpetrators of family violence/ police family violence investigators Case management for domestic violence cases Multi-agency public awareness initiatives including NPiS	Sustainable funding commitment from ACC – uncertainty has undermined programmes Need funding security & workforce capacity for on-going work
Crime prevention	Programmes focused on reducing inner city violence (1) Mellow Yellow' – city 'yellow jacketed' patrols (2) Liquor Licensing Accord – a combined agency agreement (3) establishment of alcohol reduction officer (4) Rugby World Cup initiative – 50 Police on patrol when games were on in NP – just 1 arrest	No actual evaluation done to back up claims of effectiveness – 'but hard to evaluate something that doesn't occur'
Self-harm /suicide Prevention Like Minds Taranaki Otago University Suicide Research project	'Turn the Page' resource – district libraries now stock in Puke Ariki & other library outlets Only indirectly involved in Suicide Prevention Coordinating Group – previous coordinating model not effective – 12 people attending/ merely round robin approach / not much else	NPiS to provide more focus on self-harm and suicide prevention programmes in the future Review has suggested group should act on recommendations in the NPiS suicide prevention needs assessment - set meeting agenda & activities around the recommendations

Table 11.4 (continued)

Agencies' focus	Most effective programmes	Possible ways to improve programmes
Older people TDHB Older People's portfolio	Tai Chi falls prevention programme – evaluated. Results showed programme to be very effective Active in Age for 55+ age group TDHB falls prevention video Plan to introduce well evaluated Vitamin D tablets distribution programme	Require sustainable funding stream from ACC to maintain falls prevention programme – funding uncertainty has undermined Tai Chi falls programme
Road safety NZ Police Road Safety Coordinator	(1) Seat belt & alcohol road campaigns (2) high visibility check points (3) moving car cell phone use (4) car restraints including children – not campaigns as such but targeted Police activities (5) Fatigue Stops – collaborative with ACC, supermarket outlets (6) Boy racer initiatives – Police targeting, NPDC bylaw enacted, Private purpose built 'boy racer skid track' at Inglewood – result of an NPDC focus group (7) targeting road black spots, zero-alcohol limit for young people (8) intersection red light hand-held video recording monitoring	Introduce stationary video recording boxes at red light intersections – base on successful Auckland CBD pilot – detection and identification of red light runners Education okay good but penalties the most effective deterrent

NPiS and New Plymouth Safe Community

In this section 'NPiS' means the wider collaborative network of local groups and organisations, not the NPiS Trust itself (see the discussion on the Trust later in the chapter). This section looks at the consultation participants' experiences and views of the activities of NPiS and the New Plymouth Safe Community. (This excludes NPiS governance issues which are discussed later in this chapter.)

Awareness of New Plymouth Safe Community

The needs assessment assumed that both the NPiS and stakeholder groups were already aware of New Plymouth Safe Community, as they are involved with it. The group of general / health interviewees were asked if they were aware of the Safe Community before they had been invited to take part in the needs assessment. Only one person of these 11 had not already heard of it.

Roles / functions of the Safe Community

General / health interviewees

General / health interviewees believed the functions or roles of the Safe Community were to:

- collaborate, provide a coalition / partnership / intersectoral group with common goals (8)
- work to reduce injuries in community, create safe environment (4)
- undergo Safe Community accreditation, provide external expectation of standards achieved, foster pride in what the community is doing (3)
- identify priorities and develop (overarching) strategies (2)
- inform the community about / promote safety issues, create awareness (2)
- monitor (2)
- provide an inclusive process for Māori (1)
- move from injury to broader safety issues (1).

NPiS members

NPiS members were asked what they believed were the *most important* functions or roles of the New Plymouth Safe Community programme. As might be expected, roles and functions identified overlapped considerably with those of NPiS itself, and were to:

- foster / support / facilitate / deliver injury prevention initiatives / activities (3)
- provide networks / build relationships and partnerships, work collaboratively (3)
- conduct regular needs assessments, monitor effectiveness of work (3)
- disseminate / share information (2)
- promote Safe Community messages, assist in meeting Safe Community criteria (2)
- advocate (1)
- scope for new initiatives (1).

Stakeholders

Stakeholders were not asked about their understanding of the roles or functions of the Safe community.

Effectiveness of NPIS / Safe Community

The needs assessment asked all three groups of community consultation participants if the Safe Community was currently making a positive difference in preventing injuries and promoting safety in New Plymouth District. That is, does it add anything extra to the work other local groups are already doing? (In the case of stakeholders and general / health interviewees, they were asked if NPIS / the Safe Community was making a positive difference). The majority of participants (25) believed that NPIS / the Safe Community was making a positive difference in at least one way (table 11.5). Six were unsure.

Table 11.5
Has NPIS / New Plymouth Safe Community made a positive difference?

Has Safe Community (/ NPIS) made a positive difference?	Stakeholders	General / health interviewees	NPIS members	Total
Yes	11	7	7	25
No	0	0	0	0
Don't know / not sure	2	3	1	6
Not applicable*	0	1	0	1
Total	13	11	8	32

Notes: * not applicable because had not heard of the Safe Community.

Ways in which NPIS / the Safe Community make a positive difference

Community consultation respondents identified the following ways NPIS / the Safe Community had made a positive difference in preventing injury and promoting safety in New Plymouth District:

- promoted networks, collaboration and partnerships between organisations / groups (4 stakeholders, 3 general / health interviewees, 3 NPIS members)
- provided education, information, publicity which have increased awareness and motivation – through the newsletter, website, seminars, *Midweek* newspaper column and creative messages (2 stakeholders, 6 general / health interviewees, 2 NPIS members)
- led the accreditation and re-accreditation of New Plymouth Safe Community, gaining international recognition, and ensured that the WHO criteria are met (3 stakeholders, 2 general / health interviewees, 1 NPIS member)
- been proactive in identifying gaps and priorities and promoting evidence-based action (1 general / health interviewee, 4 NPIS members)

- led the needs assessment and collected statistics (1 stakeholder, 1 general / health interviewee, 2 NPiS members)
- supported partners to get funding and acted as a fundholder for them (4 NPiS members)
- co-ordinated injury prevention work (2 stakeholders, 2 NPiS members)
- supported and promoted partners' programmes / activities (1 stakeholder, 2 NPiS members)
- provided a cohesive umbrella / community safety banner for related organisations (2 stakeholders)
- helped to establish a community safety culture in the district (1 stakeholder, 1 general / health interviewee)
- initiated new groups and programmes (1 general / health interviewee, 1 NPiS member)
- attracted support from key people and organisations (1 stakeholder, 1 general / health interviewee)
- been especially effective when there was a programme manager (1 stakeholder, 1 general / health interviewee)
- led the community safety strategy (1 stakeholder)
- created a focus (1 general / health interviewee)
- become well known (1 stakeholder)
- been very professional (1 stakeholder)
- reduced injury in some areas (1 NPiS member).

In addition, two stakeholders emphasised what a good job NPiS had done – 'does a brilliant job', 'keep up the good work'. Another said that injury prevention would have dropped off their radar if Kath Forde had not been there (in the absence of a programme manager). One general / health interviewee suggested that 'without it, things might go backwards'.

However, several general / health interviewees were unsure if NPiS / the Safe Community had made a positive difference in certain ways:

- not sure if outcomes have improved (3)
- not sure if audience takes messages on board (1)
- 'not overwhelmed by it. Does put a stake in the sand, but is a quite expensive and wordy way of doing it' (1)
- still see a lot of injured people – can't do much about people who make risky choices (1).

Working with stakeholders

Five of the 13 stakeholders indicated their agency had a direct relationship with NPiS due to one of its members being in the NPiS group or on its Trust. Another five agencies had an indirect relationship, either through working collaboratively with NPiS on particular programmes, attending the committee meetings of other agencies, or through networking. One agency said the NPiS newsletter was the only connection they had with NPiS, while another said his agency had no relationship other than that both agencies worked under the same umbrella on a specific issue.

Recent changes to NPiS's structural arrangements had reportedly been the main change for two stakeholders. Both were formerly members of the NPiS network group but had since become NPiS Trust members. For one of these stakeholders, the changing membership of NPiS had meant that the direction of NPiS had changed, meaning it became consistent with the direction of his agency. The other stakeholder said membership of the Trust had strengthened the position of her agency.

The loss of the NPiS programme manager due to funding uncertainty around the position had resulted in a loss of direct contact for three stakeholders with a related drop in media attention. The death of Dr Alan Parsons (founding NPiS member) was also considered to have 'left a huge gap'.

Support from NPiS

The needs assessment also asked stakeholders if they had had any support from NPiS / the Safe Community for their programmes or activities. Several agencies worked collaboratively with NPiS when programmes fitted the strategic direction of the agencies concerned. NPiS also provided funding for an initiative when ACC withdrew its funding, and helped to fund World Suicide Prevention Day (despite it being held in Hawera, a town outside New Plymouth District). Two stakeholders referred to the useful 'on the ground' support they had received from the past NPiS programme manager.

Ways in which support useful

Ten stakeholders commented on the ways NPiS's support had been helpful:

- on the ground / practical support, including media access, from NPiS programme manager was invaluable (5)
- provided useful linkages with other agencies (3)
- NPiS members' expertise appreciated (2)
- mutually beneficial (1)
- 'good to be part of bigger picture' (1)
- collaboration limits duplication of effort (1).

Ways in which support not useful

None of the stakeholders considered any of the NPiS support they received was not useful. However, one mentioned a community group that had wanted to maintain its own branding rather than use that of NPiS / the Safe Community.

Additional support

Three stakeholders identified additional ways in which NPiS / the Safe Community could support the work of their agencies or their area of interest. Two wanted NPiS to employ another 'on the ground' NPiS programme manager. One suggested that 'ACC get back into supporting this role as it works directly to reduce injuries ... which is an important part of its mandate.'

Other programmes NPiS should support

Nine stakeholders identified the following programmes / initiatives they considered NPiS should support (table 11.6).

Table 11.6
Suggested programmes / activities that NPiS should support
Stakeholders

Interest area	Programmes/ initiatives needing support
Alcohol	'Mellow Yellow' and the Central Business District Accord (liquor licensees)
Road Safety	Red Light Intersection Initiative – advocacy and promotion
Workplace	Run a seminar on workplace bullying. Huge gap out there. DOL currently provides mediation services, but can do little else to help unless it meets the service's core business criteria. NPiS would also need to identify support agencies for referral purposes as part of the preparatory work to developing the seminar
Children's injuries	<p>More advocacy work required to promote child safety initiatives. These should be evidenced-based. Requires a focus on the more vulnerable groups & their parents especially in these times when funding has 'tightened up'</p> <p>As a community need to focus on children using a collaborative approach. KidSafe good but need more work as 'accidents continue to happen'. 'NZ has an appalling record for children's injuries both intentional & unintentional'.</p>

Table 11.6 (continued)

Interest area	Programmes/ initiatives needing support
Suicide prevention	<p>More to prevent intentional self-neglect among the elderly. This group figures prominently in local suicide statistics</p> <p>Work collaboratively to revitalise the Regional Suicide Prevention Group. Encourage to use NPiS suicide prevention needs assessment to help group develop a regional action plan</p> <p>Promote development of a media training workshop to train media and NPiS media spokesperson who recently wrote Midweek column on suicide. Promote use of the MLI Suicide prevention Projects website training programme</p>
Family violence	Taranaki Safe Families initiatives – advocacy and promotion
Crime prevention	Needs to focus on crime prevention. Has traditionally been a weak area for NPiS. Requires a true commitment to maintain NZ Police buy-in. Identify champions to promote and advocate this and other interest areas as well.

Programme manager

As already discussed (see chapter 1) the NPiS Trust first employed a programme manager – Channa Perry – in January 2007. Due to the uncertainty over future funding for her salary, she left this position at the end of 2010, and no replacement has been made.

Functions / role

The current needs assessment asked NPiS members to list the main functions of a programme manager. Six of the eight respondents described at least one of these functions. The two most commonly-listed functions were networking / relationship and partnership building (listed by 5 NPiS members) and publicising / marketing / promoting / raising the profile of NPiS and injury prevention / community safety (4). The next most common functions listed were identifying gaps in programmes / interventions (3) and supporting groups to develop and run programmes / interventions (based on evaluation / research evidence) (3).

Other functions listed were:

- co-ordination and administration of community activities and programmes (2)
- developing /facilitating new initiatives and new groups to meet priorities (2)
- advocacy (2)
- monitoring / reporting (2)
- implementing NPiS strategies according to workplan (2)
- financial administration and reporting (2)

- sharing / disseminating information (1)
- providing a secretariat for NPiS (1)
- understanding community safety issues and a 'whole of community' approach (1)
- leadership in community injury prevention (1)
- planning and evaluation of NPiS strategic plans (1).

Importance of having a programme manager

The eight NPiS members were also asked how important it was to have a programme manager. Six said 'absolutely essential' and two said 'very important'.

Looking back to the programme manager's appointment in 2007, four of the eight NPiS members agreed this had made a noticeable difference to the effectiveness of NPiS or local injury prevention and community safety programmes or activities. Four said they did not know if there were any differences, mainly because they were not members of NPiS at the time. Positive effects of having a programme manager were:

- 'she started networking with the entity that I worked for, sharing information, highlighting gaps and supported new initiatives'
- 'she raised the profile of NPiS, established effective relationships with the Trust and community partners. Supported existing programmes and had the skill to fill the gaps by establishing a Suicide Prevention Group and developing a Falls Strategy. Brought fresh ideas and had a strategic approach to most activities.'
- 'she strengthened the networks significantly, implementation of a website assisted community groups, huge increase in publicity for community groups, once a gap was discovered, e.g. suicide prevention, was able to invite appropriate groups in to the network to fill the need.'
- 'we were very fortunate to recruit an exceptional programme manager who was able to very quickly raise the profile of the safe community programme. Our programme manager was able to support existing groups, initiate innovative projects, provide research, assist with funding applications and accountability reports, promote the activities of all involved in safe community initiatives through media and our monthly newsletter and establish our website as an important community resource.'

Effects of losing the programme manager

Stakeholders

Ten of the 13 stakeholders indicated that the loss of the programme manager had made a noticeable difference to the effectiveness of local injury prevention and safety promotion programmes / activities, particularly in terms of:

- NPiS's profile having dropped off (3)

- loss of high media profile (3)
- lack of on-the-ground action (2)
- lack of 'go-to recognised front person' (1)
- much less networking now (1).

Stakeholders described the former programme manager as: 'dynamic', very positive', 'worth her weight in gold', 'a great believer in what she was doing, having achieved a good media profile', great networker, 'ideas person', and 'enthusiastic'.

Two stakeholders said that NPIS could do 'so much more' when the programme manager was involved, and another two said NPIS needed to get a replacement coordinator/ programme manager.

NPIS members

The needs assessment asked NPIS members 'did the loss of the programme manager at the end of last year [2010] lead to any missed opportunities or problems for NPIS or local injury prevention and safety promotion programmes / activities?'. Four NPIS members said this had occurred, while four were unsure (although one of these people said she 'suspected that it did').

While several NPIS members stated that the organisation has managed to 'tick over' and has maintained some of its routine functions, most of the extra work had been done by a few NPIS members (2), and this is not a sustainable or effective situation (2).

The most commonly-mentioned issue was the reduction in NPIS's community profile and visibility, because of lack of media coverage and the fact no single person is representing NPIS any more (3). On the latter point, one NPIS member suggested groups being supported by NPIS members do not realise this is the case, because they assume the members are giving support through their employing agency rather than through NPIS (1).

Another perception was that NPIS has not been able to be involved with community programmes and activities as much as before (2) and this has meant some groups and activities have stalled (2). One NPIS member said NPIS itself has lost momentum (1) others identified a delay in achieving NPIS's annual objectives (2) and not developing an annual action plan (1).

Two NPIS members also thought that NPIS's involvement with Safe Communities Foundation New Zealand and with other national and international safe communities has also decreased (2).

One NPIS member said they would not know if they had missed any opportunities, because they don't have a programme manager to identify these opportunities.

General / health interviewees

While general / health interviewees were not asked a specific question about the loss of the programme manager's role, some of them made comments about this in response to other interview questions (see other sections).

Website

Awareness and use

Both the stakeholders and the general / health interviewees were asked if they had heard of and used the New Plymouth Safe Community website (www.safetaranaki.org.nz). A total of 11 of these interviewees had visited the website, with an additional two saying their organisation contributes to the website.

Six had heard of the website but had never visited it, and three had never heard of it at all (table 11.7 overleaf).

One additional interviewee said there was no time to visit websites not directly related to work, and one looked at the website specifically to prepare for the interview.

Table 11.7
Awareness and use of New Plymouth Safe Community website

	Stakeholders	General / health interviewees	Total
Never heard of it, never visited it	0	3	3
Heard of it, but never visited it	3	3	6
Visited the website once or twice	3	5	8
Visited the website several times this year	3	0	3
Other	4	0	4
Total	13	11	24

Source: 2011 needs assessment

Reasons for using

Stakeholders and general / health interviewees who said they had visited the website had done so to:

- access useful documents e.g. the needs assessment, statistical data, strategy documents (3 stakeholders, 1 general / health)
- keep abreast of the issues posted on the website in the areas of interest to particular agencies (3 stakeholders)
- input data into agencies' interest areas (2 stakeholders)
- find other organisations relevant to their agency (1 stakeholder, 1 general / health)
- see what the re-vamp of the website is like (1 stakeholder)
- follow up an item of interest in the newsletter (1 general / health)
- see photographs of something they had done for NPIS (1 general / health)
- look at it after accreditation and reaccreditation (1 general / health)
- look at information on the Green Prescription (1 general / health).

In addition, one stakeholder referred people to the website regularly, though personally used it infrequently.

Reasons for not using

Two stakeholder interviewees who had not used the website said they had no time to do so. Another said he would only use it if it was pertinent to his organisation's work area.

Useful features

Stakeholders and general / health interviewees found the following features of the website to be most useful:

- ability to see what other agencies are doing in their interest area (4 stakeholders)
- documents and statistics on the website, for monitoring and evaluation purposes (2 stakeholders, 1 general / health)
- ability to directly input own material onto the website (2 stakeholders)
- ability to advertise own organisation's workshops (1 stakeholder)
- ability to check up-and-coming events (1 stakeholder)
- the ease of getting around the website (1 stakeholder)
- the improved layout of the website (e.g. the tabs are good) (1 general / health)
- ability to follow links from the newsletter (1 general / health)
- information on specific issues (e.g. ways to reduce risk for clients) (1 general / health).

In addition, two stakeholders said the website is generally useful, without specifying particular features.

Features that are not so useful

When asked about the website's features they found not so useful, the most common comments were:

- don't know / not sure / can't say / can't remember / nothing in particular (4 stakeholders, 2 general / health interviewees)
- it is useful / adequate as it is (5 stakeholders).

One criticism was that the website may be too 'busy' in its design (1 stakeholder, 1 general / health interviewee). This may make it hard to navigate (1 stakeholder). On the other hand, it depends on which audience the website is targeting (for example, the design may be suitable for engaging a more general community audience) (1 general / health interviewee).

A more general criticism was that people who are less computer-literate may find it a struggle to use (1 general / health interviewee).

Satisfaction with website

In a related question, members of the NPiS Trust itself were asked if they were satisfied generally with the Safe Community website (it was assumed they had heard of it and visited it). Six NPiS Trust members said they were satisfied, one said he was sometimes satisfied and one said she did not know.

Suggested improvements

All three groups of needs assessment participants were asked for their suggestions about how the New Plymouth Safe Community website could be improved. The most common suggestions were:

- employ someone to actively update and review the website and encourage people to use it (1 stakeholder, 2 general / health interviewee, 2 NPiS members)
- make the front page less busy / clearer (3 stakeholders)
- make it more visually appealing – 'a bit bland looking' 'the technology is changing fast' - 'need to keep up with the play to please today's experts' (1 stakeholder)
- provide different access points for each of the relevant sectors 'especially for those new to the game' (1 stakeholder)
- provide different areas of the website for the general public and for those who work in the area (such as partners) (1 general / health interviewee)
- use it more effectively for media releases and information on current events (1 general / health interviewee)
- use it as a repository for information about NPiS (1 general / health interviewee).

Newsletter

Receiving and reading

Both the stakeholders and the general / health interviewees were asked if they received and read the NPiS newsletter 'Community Update'. The newsletter is sent each month by email to a list of people and organisations, and is also available on the Safe Community website.

A total of eight of the 24 interviewees read the newsletter every month and nine looked at it each month, but read only items that interested them.

A further two glanced at the newsletter occasionally but hardly ever read any items, and one had seen the newsletter, but had never read it. Three had never seen or received the newsletter (table 11.8).

Table 11.8
Receipt and use of New Plymouth Safe Community newsletter
Stakeholders and general / health interviewees

	Stakeholders	General / health interviewees	Total
Never seen or received it	2	1	3
Seen it / receive it, but never read it	1	0	1
Glance at it occasionally, hardly ever read any items	0	3	3
Look at it every month, usually only read items of interest	5	4	9
Read the whole newsletter every month	5	3*	8
Total	13	11	24

Source: 2011 needs assessment

*Note: One of these people had not read it for a year as she had not received it since the programme manager had left.

Forwarding the newsletter

Seven stakeholders and four general / health interviewees who read the newsletter said they usually forwarded it to other people as follows:

Stakeholders	General / health interviewees
<ul style="list-style-type: none"> • Forwards it to 3 other team members • Forwards it to about 100 others • Forwards to about 6 others, and to particular people if articles relevant • Forwards it to 7 staff • Forwards it to 2–3 others • Forwards it to a team • Available on work tea table 	<ul style="list-style-type: none"> • Forwards it to 3–4 other people • Forwards it to about 30 people • Available on coffee room table for about 40 people • Prints it out for course participants

Useful features

Overall, most stakeholders and general / health interviewees who had read the newsletter responded favourably to this question in terms of liking it and finding it useful. The most common comments were:

- it is brief – ‘a one-pager’ (4 stakeholders, 3 general / health interviewees)
- simple, easy to read, understandable (3 stakeholders, 2 general / health interviewees)
- chatty, newsy, interesting, engaging (2 stakeholders, 2 general / health interviewees)
- it is good to know what is going on and what is coming up, keeps you up to date (3 stakeholders, 3 general / health interviewees)
- informative (3 general / health interviewees)
- good pictures, photos (2 stakeholders)
- information on Māori community (1 general / health interviewee).
- information on primary care (1 general / health interviewee)
- good articles (1 stakeholder)
- identifies points of contact (1 stakeholder)
- well set out – you can see at a glance what is relevant (1 stakeholder)
- ‘it’s good to have a celebration of what’s happening in our community’ (1 stakeholder).

Features that are not so useful

Most stakeholders and general / health interviewees who had read the newsletter did not think it had features that were not useful.

However, one stakeholder said the newsletter was not applicable to his work, and one general / health interviewee questioned how relevant it was and how much impact there was for quite a lot of work. One general / health interviewee wondered if she needed to receive it so frequently as injury was just one of multiple priorities she was dealing with (although she acknowledged other people may need to receive it monthly).

One stakeholder noted having never seen anything in the newsletter that was specific to Māori in the past. However, she also reported having seldom read the newsletter.

One stakeholder and one general / health interviewee found the newsletter's layout quite 'busy', with a lot crammed into a small space and the latter interviewee also thought the print was too bold. Another two general / health interviewees said the large file size sometimes caused difficulties.

Finally, one general / health interviewee said that there is some confusion about whether the newsletter relates just to NPiS or to the New Plymouth Safe Community. It is currently branded as being the NPiS newsletter, and its content is still mainly about reducing physical injuries, rather than wider safety issues relevant to the Safe Community.

Satisfaction with newsletter

In a related question, members of NPiS itself were asked if they were satisfied generally with the newsletter. Seven NPiS members said they were satisfied, and one said he was not satisfied.

Suggested improvements

All three groups of needs assessment participants were asked to suggest improvements to the newsletter. Several people made suggestions, including the following:

- make the newsletter slightly longer (e.g. 2 pages) so that information is not so 'busy' (1 stakeholder, 1 general / health interviewee)
- redesign to look more attractive (1 NPiS member)
- use more graphs to help reduce the number of words (1 stakeholder)
- send out the newsletter slightly less often (1 general / health interviewee)
- have a link to the newsletter on the website instead of sending out large files, reduce size of file (1 stakeholder, 2 general / health interviewees)
- have a kete / corner for Māori news and issues (1 general / health interviewee)
- raise opportunities for people to get involved in the Safe Community (1 general / health interviewee)
- provide information on best practice in community safety trends and education for practitioners (1 general / health interviewee)

- include information on broader safety issues, including gaps and priorities, rather than just describing specific projects by community groups to reduce injury (1 general / health interviewee; 1 NPiS member)
- may need to change the newsletter's branding from NPiS if broader safety issues covered by newsletter (1 general / health interviewee).

Programmes / activities profiled on website or in newsletter

The stakeholder group of 13 interviewees were asked if any of their organisation's programmes or activities had been profiled on the New Plymouth Safe Community website or in the NPiS Community Update newsletter. Ten of the 13 stakeholders identified programmes that had been profiled, two said none had, while one was unsure.

Specific initiatives / programmes featured included the following:

Interest area	Initiatives/ programmes identified
Alcohol	Many alcohol-related initiatives were featured between 2000-2006. New resource will be profiled at the end of Nov 2011. 'Wheel of Fortune' 'Mellow Yellow' Work at the BeST Centre Department of Labour's Drug & Alcohol Policy Trade Apprentices Challenge Construction industry programme
Road Safety	Intersection campaign Advanced Driving Day
Workplace	Apprentice Challenge Workplace specific safety messages
Children's injuries	Poisonings Child falls
Suicide prevention	'Turn the Page' Suicide Coordinating Committee Suicide prevention workshop – farmer's welfare
Older people's injuries	Training in injury prevention for rest home staff
Family violence	White Ribbon Day Blow the Whistle

Changes in the operation of NPiS / NP Safe Community

The group of stakeholders were also asked if they had noticed any changes in the operation of NPiS / NP Safe Community over the years.

Five of the 13 stakeholders had not noticed any changes (but one of these people had only recently been appointed to her current position). Six of the group who had observed changes spoke highly of the work of the former programme manager both in terms of her advocacy, promotion and networking abilities. They saw her loss as deleterious in terms of her having very effectively promoted NPiS' work programme and doing the actual ground work. They considered programme management to be very much reliant on the quality and talents of the individual working in the role. In general, they said 'Channa was very positive and effective front-person for NPiS'.

One person indicated that the NP District Council had recently abdicated their responsibilities with regards to the Safe Community programme, asking NPiS to run with the community safety side of their Long-term District Plan (LTDP). The original LTDP was considered good. However, according to this interviewee, the latest version, which has apparently gone through a 9-month ratification process, was adapted from the earlier plan but is much 'watered down' in comparison. 'Otherwise the relationship with NPDC is fine'.

Other comments on the effectiveness of NPiS / NP Safe Community

Of the 11 stakeholders who provided additional comment on the effectiveness of NPiS or the Safe Community, five commended NPiS for what they had achieved in terms of bringing agencies together to effectively work on a collaborative basis on injury prevention and safe community programmes.

Four of the five expressed concern and regret should a lack of funding and resources serve to undermine the good work NPiS had achieved. The loss of the driving force of the former NPiS programme manager was again raised as indicative of what they saw as NPiS and injury prevention losing ground.

One stakeholder did not like the NPiS / Safe Community terminology – was confused about how the two aspects work together. This interviewee suggested a need to clarify this confusion and streamline – 'need to keep it simple for the public'.

Another stakeholder said that when NPiS were approached to develop the Community Safety Strategy document, there appeared to be mixed views on whether this was a good thing, with concerns expressed about the risks to NPiS in taking responsibility for certain areas that historically had not been their issues (e.g. family violence, crime prevention).

What else can NPiS / the Safe Community do?

Both the stakeholders and the general / health interviewees were asked 'do you think there is anything more or different NPiS / NP Safe Community (in particular) could do to prevent injuries and promote safety in New Plymouth District?'³³ NPiS members were asked a similar question in relation to the NPiS Trust.

Nine stakeholders, four general / health interviewees and seven NPiS members made suggestions.

The most common suggestion was that a new programme manager should be employed, made by four stakeholders and three NPiS members. However, it was acknowledged that currently there was a lack of resources to do this.

There were also a number of people who advocated for more work in certain injury / safety areas including:

- Māori safety issues (2 NPiS members)
- intentional self harm (including suicide and non-suicide) e.g. revitalise Suicide Prevention Group, work with Bishop's Foundation, educate the local newspapers about reporting suicide, have regional action plan (2 stakeholders)
- family violence (1 stakeholder)
- workplace e.g. identify needs and Trust could broker workforce training (1 NPiS member)
- physical access to homes (1 general / health interviewee).

There was some disagreement on how much NPiS should do 'on the ground' itself. One stakeholder said that NPiS was not very practical, and another said NPiS should concentrate on action and practical work rather than strategic planning. On the other hand, two NPiS members said NPiS should work more strategically, provide an overview and publicity, with representation from organisations that can work on the ground, rather than the Trust working on the ground itself.

Other specific suggestions were that NPiS / the Safe Community should:

- promote some injury prevention activities at Christmas time (1 stakeholder)
- continue the *Midweek* newspaper column (1 stakeholder)
- use radio to promote messages (1 stakeholder)
- encourage and support groups to evaluate their programmes, make changes in line with the evaluation results and give conference presentations about effective programmes (1 NPiS member)

³³ General / health interviewees had already been asked a more general question about what should or could be done to prevent injuries or threats to people's safety (see previous section).

- invite community groups to Safe Community workshops / meetings (1 NPiS member)
- formalise membership of the network in some way (1 NPiS member)
- make part of the programme manager role specific to Māori (1 general / health interviewee)
- cover the whole of Taranaki to include people / whānau living in the rest of Taranaki which has rural and some disadvantaged areas (an equity issue) (1 general / health interviewee)
- advocate and lobby more politically, to shift the middle ground on injury / safety issues (1 general / health interviewee)
- develop a big overall vision to achieve a really collective approach to all local safety issues, and involve every relevant community organisation (1 general / health interviewee).

Other comments in response to these questions included two general / health interviewees saying NPiS / the Safe Community do a really good job. They believed NPiS covers a massive area with few resources. Another general / health interviewee said NPiS / the Safe Community have performed a good advocacy role at the local level, which is essential as injury is not one of the national health priorities any more, meaning a lack of action by some government health agencies in this area.

One general / health interviewee said she had not heard as often from NPiS / the Safe Community after the programme manager left.

The NPiS Trust

This section looks at the operation of the NPiS Trust itself, from the perspective of the eight NPiS Trust members who completed the email survey. This includes some governance issues.

Roles / functions of the NPiS Trust

NPiS members believed the *most important* functions or roles of the NPiS Trust currently were to:

- co-ordinate / encourage / initiate local injury prevention / safety promotion activities (4)
- provide networking / collaboration opportunities, initiate and maintain relationships / links between injury / safety groups (4)
- administer / co-ordinate the New Plymouth Safe Community and its activities, ensure Safe Community criteria met (4)
- monitor / gather / provide information and data on injury issues and outcomes (3)
- employ a programme manager (2)
- obtain funding for NPiS functions, e.g. employing a programme manager (2)
- identify priorities/ gaps in injury prevention and safety programmes (2)
- provide information about local initiatives (2)
- provide support / assistance for local injury / safety groups (1)

- provide representation of community safety partners (1)
- advocate in the community(1).

Benefits of belonging to NPIS

All eight NPIS Trust members said their organisations benefited from belonging to NPIS. These benefits included:

- reductions in injuries will put less pressure on their own organisations (which deal with the management of injuries and their consequences) (4)
- can work in partnership / collaborate with others (2)
- allows us to interact and get messages to audiences / key target groups (2)
- share the burden of injury issues with others, including those who should take some responsibility (2)
- ensures Māori participation and connectedness to Māori communities (1)
- enjoy the success of NPIS (1)
- because NPIS has Safe Community designation, can attract resourcing and expertise from partners and funders (1)
- keeps the organisation involved in injury issues (1).

Costs of belonging to NPIS

Six of the eight NPIS Trust members agreed that belonging to NPIS cost their organisation in some way, and two said it did not. The main costs were time and funding.

In terms of time, this was related to attending meetings and events, and work time involved in matters such as applying for funding and International Safe Community accreditation, responding to e-mails, interacting with the programme manager and doing her work after she left NPIS.

Three of the NPIS members said their employing organisation funded NPIS activities – mainly the salary for the programme manager and in one case ‘numerous programmes’ as well.

Other resources contributed by members’ organisations included accommodation and cheap use of a car for the programme manager.

All six NPIS members whose organisations contribute resources to NPIS said this contribution was reasonable. Comments about the reasons for this view were:

‘If the programme works effectively, health benefits hugely.’

‘The above costs are reasonable. They become unreasonable when the level of funding and support continues but outcomes are not being achieved.’

‘Absolutely reasonable. More than happy with the commitment level required right now.’

‘We believe we get good value for money.’

‘Weighed against the costs [of dealing with injuries] this could certainly be considered reasonable so long as the programme delivers, or seems likely over time to deliver, injury prevention outcomes that contribute to a reduction in [the costs of dealing with injuries].’

Adding further members to the NPIS Trust

NPIS members were asked if any other local organisations or groups should belong to the NPIS Trust governance group. Four said ‘no’, three said ‘don’t know’ and one said ‘yes’.

Reasons cited for not wanting further members were that the Trust already consists of the key players and, between them, they have links to every relevant local community group. The view was that it is important to keep the group to a manageable (small) size so that decisions are made and acted on. Also NPIS members believed there should be an emphasis on appropriate skills (to advance the work of NPIS itself) rather than representation from every possible group.

The one person who said there should be more groups on the Trust suggested the following: Be Safe Taranaki (BeST); Taranaki Safe Families Trust, Roadsafes Taranaki, and representatives from community justice and civil defence.

An additional person stated that the answer to this question would become more obvious once the needs assessment was completed and priority areas were identified.

Shared vision

NPIS Trust members were asked if they thought the members had a shared vision of what the group was trying to achieve. Half (4) said ‘yes’ and half said ‘sometimes’.

Three of those who thought members do have a shared vision said this was because they all wanted a safe community. The other person who agreed said the group was able to maintain a shared vision because all members came from a community-focused background.

However, comments from those who thought they had only ‘sometimes’ a shared vision included:

‘The future structure of the Trust is currently under review. This has clouded our vision slightly.’

‘I think the vision is generally the same, however we are looking at a number of options that are challenging some aspects of this.’

‘Sometimes it is hard for us to agree on what the vision and direction actually is. Lots of robust discussion but a consensus is usually reached.’

‘There is tension within the Trust about what the vision is and how to achieve this. This stems from broadening the scope of the Trust to consider community safety as the driving consideration (consistent with the International Safe Community designation) and injury prevention, which was the focus of the Trust prior to seeking ISC accreditation.’

Working together

Nearly all (7) NPIS Trust members agreed that the Trust members generally work well together, with one member saying they sometimes do.

Suggestions by Trust members for improving how they work together included:

- increasing productive discussion time by working more through e-mails and being better prepared for meetings (2)
- employing a programme manager to ensure better co-ordination (1)
- sharing tasks more evenly (1)
- having a clear agreement and commitment on the future direction of the Trust – ‘there has been very little action and decision-making undertaken by NPIS in the past 12 months’ (1).

Working with Māori

When asked if they thought NPIS generally worked well with Māori, three NPIS Trust members agreed that they did, four said ‘sometimes’ and one said ‘no’.

Four Trust members stated that their working with Māori could be improved through continuing to try to find ways of reducing injury among Māori (if / where the evidence suggests there is a particular problem). However, one of these members was not sure that NPIS was ‘an effective vehicle to deliver on kaupapa Māori community safety programmes’.

One Trust member suggested linking with Te Whare Punanga Korero or the Māori health unit, while another commented that ‘NPIS works well with all ethnic groups’.

Communicating

In response to the question ‘generally, do you think NPIS members communicate well with one another?’, five Trust members said ‘yes’, and three said ‘sometimes’.

Regarding possible improvements to communicating, one person thought emails could be used more. Another said NPIS Trust members could be a bit more responsive to emails.

One Trust member said that ‘not having a full time co-ordinator has its challenges’; and another thought that, in the absence of a programme manager it would be good to have more face-to-face contact between Trust members and ongoing involvement with NPiS business.

Another suggested ‘the Trust needs to be more purposeful on the expected roles of Trust members and what the desired outcome at Trust meetings is. Is it to provide governance to the Trust or is there a broader role around discussing joint community safety initiatives and co-ordinating efforts around this?’

Other comments were that it was a comfortable situation contacting other Trust members for any purpose (1), generally there is excellent communication both at meetings and by e-mail (1), for special projects two or three people meet together to progress the work, which is useful (1).

Meetings

All eight NPiS Trust members agreed that generally their meetings were useful and well-organised. However, they did suggest a few possible improvements:

- improve chairing of meetings so there is a better balance between discussion time and formal procedures – meaning resolutions can be made and everyone has a say (2)
- improve timekeeping as people need to leave the meeting if it runs over time (1)
- better preparation for the meetings (1)
- have a clear agenda and expectation of what will be discussed (1)
- ‘we need to decide on key strategic areas and commit time, resource and funding to support action in the community to make a difference’ (1)
- a co-ordinator would add value (1)
- could separate governance meetings from general meetings (1).

Funding

The next question for NPiS Trust members asked ‘generally, do you think the processes for getting funding for NPiS work well?’. This was the area of most dissatisfaction for Trust members, with only one saying ‘yes’, four saying ‘sometimes’ and three saying ‘no’.

According to several Trust members, the main problem was that NPiS has three main funding sources (the Accident Compensation Corporation [ACC], Taranaki District Health Board and New Plymouth District Council). Over several years this funding was sufficient to employ a programme manager, but ACC reduced its funding making the total funding insufficient for this purpose. This funding uncertainty led to the programme manager’s resignation. Since then, no other funding source has been identified and it has been a slow process.

Three NPiS Trust members thought that NPiS should agree on a policy concerning applying for funding, including which sources are acceptable and which are not (e.g. should they apply for Lottery funding?).

Another Trust member said that having a co-ordinator would help in applying for funding, as they would be in a better position to research funding possibilities.

One more Trust member commented that funding is hard to find for any community group. Another cited the current economic climate as causing the lack of funding opportunities. One Trust member said 'it would be far better to have established a secure funding source so we could focus more on service delivery. This could be either from local or central government level'.³⁴

Other improvements to NPiS processes

Four of the eight NPiS members made further suggestions for improvements to NPiS processes:

- increase representation from other community safety partners (1)
- a better induction programme for new members of the Trust (1)
- a written agreement for Trust members outlining their role and responsibilities (1)
- more policies on how NPiS operates (1)
- only Trustees should be allowed to vote on governance issues at meetings, as other attendees are not accountable for decisions made (1).

Achievements of the NPiS Trust in 2011

NPiS members listed their achievements (in the context of not having a programme manager) over the past year. The most comprehensive reply from one person was the following:

- 'Completed an externally facilitated process to review our governance and have been implementing the recommendations.
- Agreed to take responsibility for progressing the draft community safety strategy developed through a consultation process led by NPDC
- Initiated and contracted the third five-yearly injury needs assessment including developing the research plan in consultation with the researchers
- Accessed a funding contribution towards the needs assessment
- Managed the reports to SCFNZ and existing funders

³⁴

In December 2011 ACC announced a new funding formula for New Zealand Safe Communities. This announcement was made after completion of the survey of NPiS Trust members.

- Provided training to several key partners to enable them to directly add material to the safe community website
- Maintained the delivery of the monthly newsletter by contracting out for first six months then by one of the trustees taking responsibility for it
- Maintained the financial spreadsheet throughout the year providing detailed reports to monthly Trust meetings
- Hosted a forum for the Injury Prevention Network to consult the community on its strategic plan
- Attended ISC meetings and contributed to IP news
- Hosted a visiting expert on older adults falls prevention and arranged three presentations to professional groups and general public
- Supported the following community groups and projects either financially, practically or both:
 - Taranaki Safe Families Trust – Blow the Whistle Campaign
 - Taranaki Suicide Prevention Co-ordinating Group – World Suicide Prevention Day
 - Taranaki Motorcycle Safety Group – Rider Training Days
 - Road safety project team – Ready2Drive expos in secondary schools
 - Agricultural challenge project team – Taranaki Secondary Schools Agricultural Team Challenge
 - Be Safe Taranaki – Apprentices Safety Challenge
 - Regional Falls Prevention Group – delivered NPIS falls prevention training to rest home staff.'

Additional achievements mentioned by other NPIS members were:

- the ongoing profile of NPIS on its website
- column in the *Midweek* community newspaper
- managed the re-accreditation event
- secured further funding from partners
- agreed to broaden focus on community safety.

Future of the Trust

When asked what they saw as the future role of NPIS, the most common responses NPIS Trust members gave were: to continue as the local co-ordinating body, establishing and strengthening networks (4); and to continue or become more proactive in raising awareness and motivating people to reduce injuries and increase safety (4). Other roles were to:

- continue to highlight issues and disseminate information (2)
- understand and support best practice / evidence-based community initiatives (2)
- research / monitor / analyse the situation in New Plymouth District (2)
- maintain / look after the District's Safe Community status (2)
- provide an annual overview to stakeholders of progress against the community safety strategy (1)
- get funding for a programme manager (1)
- encourage local organisations to adopt and promote safe practices in the workplace (1)
- assist community groups (1)
- facilitate new initiatives where gaps are found (1)
- keep in sight the end goal (1)
- be represented on local government forums related to community safety strategies (1)
- follow the draft strategic plan (1).

NPiS Trust members were also asked if they believed any changes to NPiS's role would be needed as the result of currently-known circumstances. While some said NPiS did not really need to change its role, they made the following comments about what NPiS needed to do in the current circumstances:

- need to be aware of, and responsive to funders' expectations and requirements, including achieving outcomes (3)
- may need to broaden NPiS's scope / expand its vision (2) but still stay true to the core function (1)
- could work more closely with the BeSafe Centre e.g. to prevent duplication (2)
- find a way to sustainably finance a programme manager as well as safe community activities (1)
- need to be aware of political environment and legislative change (1)
- need to maintain and grow NPiS's base of information and needs assessments (1).

NPiS Trust members believed the most important thing that NPiS should do next was to secure funding for employing a new programme manager / co-ordinator (4). Two NPiS members thought that they should get the community safety strategy completed, and two believed it was very important to develop an annual action plan for the Trust itself. A further Trust member said 'complete strategic planning process and agree on key focus areas. This will allow for a co-ordinated action plan to be implemented and make a difference in the community'.

One NPiS Trust member said the Trust should formalise relationships with community safety groups and increase representation, to achieve a 'whole of community approach'. Another member

suggested NPiS should 'continue the work with the existing Trust members to realise our new direction'.

Community safety strategy

Finally, stakeholders and general / health interviewees were asked to give feedback on the draft New Plymouth Community Safety Strategy (the summary diagram from the strategy is shown in figure 11.1 overleaf – a full version of the draft strategy is in Appendix Volume Two). The draft document had been sent to people before they were interviewed so they could look at it in advance, although not all interviews had time to do so.³⁵

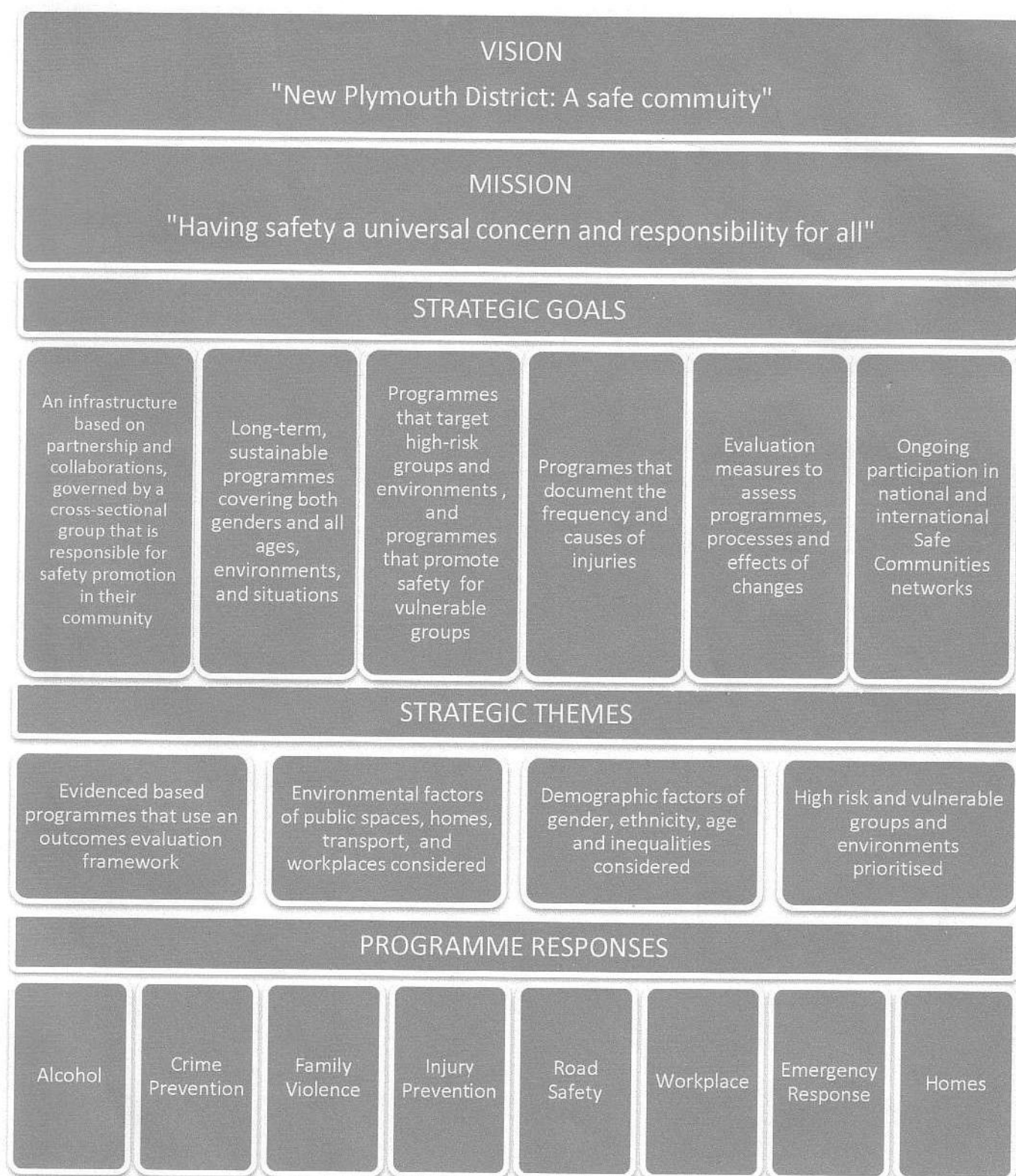
Initial comments

Before asking them more specific questions, we asked interviewees for their initial responses to the draft strategy.

Of the 13 stakeholders, four had not read the strategy, four generally liked it, and three were less positive. Some of them also had editorial comments.

³⁵ NPiS members also answered a similar set of questions but requested that these particular results not be published here, as NPiS itself is responsible for gathering feedback on the draft strategy.

Figure 11.1
Summary diagram of New Plymouth District Community Safety Strategy



Source: New Plymouth District Council / New Plymouth injury Safe (2011). See Appendix Volume Two: Consultation Documents for a full copy of the draft strategy.

Of the 11 general / health interviewees, two had not read it, three had no initial comments, three generally liked it, two did not like it and one had positive as well as negative comments.

The more positive of the responses were:

- it is possible to see relationships / how different organisations are connected or linked (3 stakeholders and 1 general / health interviewee)
- very thorough / comprehensive (1 stakeholder and 1 general / health interviewee)
- well put together / well thought out (one stakeholder and 1 general / health interviewee)
- like the way it looks (2 stakeholders)
- easy to read, lay people would identify with it (2 stakeholders)
- the first page of the diagram is good (2 general / health interviewees)
- it is a good concept / laudable (2 general / health interviewees)
- like the mission statement (1 stakeholder)
- it is good to take a co-ordinated approach to community safety (1 stakeholder)
- it is good to have something out there for everyone to see (1 stakeholder)
- puts people in touch with one another (1 stakeholder)
- limits the risk of duplication (1 stakeholder)
- it is achievable (1 general / health interviewee)
- it is good to have the broader safety issues included (1 general / health interviewee)
- you can understand where resources need to go (1 general / health interviewee)
- there is the potential to start building things from it (1 general / health interviewee).

On the other hand, the more negative comments were:

- it is confusing and unnecessary - why have another strategy (e.g. on top of the NPiS strategy)? (2 stakeholders)
- there is nothing specific to Māori in it, it should be cross-cultural – were any Māori involved in the development of it? (1 stakeholder)
- there is nothing specific to youth in it (1 stakeholder)
- the change from injury prevention to wider community safety compromises future Safe Community accreditation (1 stakeholder)

- it does not add anything extra to what I already know (1 general / health interviewee)
- it is written at too high a level to be practical / useful (1 general / health interviewee)
- it is laudable, but you need to make it work (1 general / health interviewee).

Suggestions for editorial improvements included:

- it needs a clear glossary / explanation of 'injury prevention and the link / role of NPiS and the Safe Community (1 stakeholder)
- needs a spell check e.g. 'community'(1 stakeholder)
- 'alcohol' under programme response should be changed to 'alcohol-related harm' (1 stakeholder)
- under strategic themes - needs Maori responsiveness specified, not just demographic factors (1 stakeholder)
- under alcohol (1st box) should have a title i.e. aim / desired outcome (1 stakeholder)
- the falls response needs to make it clear which groups are being referred to eg older people or children (1 stakeholder)
- needs 'key performance indicators' specified for evaluation purposes (1 stakeholder)
- some of the wording is 'quite airy-fairy' e.g. 'zero harm' needs 'chunkier' 'more realistic' wording e.g. 'lower the risk of alcohol-related harm ' (1 stakeholder)
- its aims are unrealistic / utopian in places e.g. 'every family violence free' (1 general / health interviewee)
- it is wordy and needs to be simplified, especially the strategic goals (1 general / health interviewee).

Is the strategy a good idea?

The stakeholders and general / health interviewees were asked if they thought it was a good idea to have a community safety strategy for New Plymouth District.

Ten of the stakeholders thought it was a good idea, one thought it was not, and two said 'yes and no'. All of the general / health interviewees thought it was good idea.

The reasons for thinking the strategy was a good idea were:

- it provides a good road map, a direction to go in (4 general / health interviewees)
- injury prevention needs a co-ordinated approach as there are a range of stakeholders involved (2 general / health interviewees)

- it provides a cornerstone for injury prevention (1 general / health interviewee)
- we have strategies for everything else, so may as well have one for injury prevention which is an important issue (1 general / health interviewee)
- it helps to see how one's own agency fits into the bigger picture (1 stakeholder)
- it provides some indicators to measure competency (1 general / health interviewee)
- it identifies the range of safety issues (1 general / health interviewee)
- it includes good programmes such as road safety, family violence and crime prevention (1 general / health interviewee)
- it is good that it includes the alcohol issue (1 stakeholder).

Criticisms included:

- NPiS already has a strategy, so another one is not needed (1 stakeholder)
- it should cover a 20-year period (1 stakeholder)
- it does not show the linkages between all the agencies (1 stakeholder).

Mixed positive / negative comments about the idea of having a strategy were:

- it provides commitment, but needs to be followed through (1 general / health interviewee)
- it has laudable aims, but I'm not sure how it is useful for my own work (1 general / health interviewee).

Will the strategy be effective?

The interviewees were also asked if they thought the Community Safety Strategy would be effective in contributing to a safer New Plymouth District.

Nine of the 13 stakeholders and seven of the 11 general / health interviewees thought it would be effective. Of these people, two stakeholders believed the strategy provided a good framework and two more thought it would encourage collaboration and co-ordination. One general / health interviewee said that it should reduce pockets of waste and duplication. She also liked the strategic emphasis and evidence-based approach across different places and demographic groups. In addition, she thought the strategy was prioritising wherever the need was greatest.

A further four stakeholders and two general / health interviewees said it would be effective, but qualified their answers. Two stakeholders were concerned it did not specifically mention Māori and

questioned if any Māori had been involved in developing it. Two general / health interviewees said it would only be as good as people's response to it, and how it is implemented or followed through. Others said it could be effective if:

- it included a mental health focus, particularly something specific to workplace bullying (1 stakeholder)
- it develops and includes key performance indicators for evaluation purpose (1 stakeholder)
- it is brought to the wider public's attention for instance through the 'Midweek' newspaper (1 stakeholder)
- agencies keep working together as they have in the past (1 stakeholder).

One general / health interviewee said she did not know if the strategy would be effective and another did not answer this question.

Priority areas

The draft strategy included eight safety priority areas or 'programme responses' which all 24 interviewees were asked to rank, in terms of how important it was for the strategy to include them. Three people said all eight areas were equally important. As might be expected, interviewees tended to rank their own organisations' areas of responsibility or interest as top priorities. The overall rankings were:

1st	Alcohol	
2nd	Family violence	
3 rd =	Crime prevention	Injury prevention
5th	Road safety	
6th	Workplace safety	
7 th =	Emergency management	Secure and Healthy Homes

In addition to ranking them, interviewees made a number of comments about each of the eight areas:

Alcohol	<ul style="list-style-type: none"> • should include drugs as well e.g. because drugs are a big problem in workplaces (2 stakeholders, 2 general / health interviewees) • should not include drugs because it is very difficult to prevent drug problems and it would take resources away from other priorities (1 stakeholder) • overlaps with other priority areas and feeds into them (2 general / health interviewees) • how is 'alcohol' defined in terms of the strategy? (1 general / health interviewee)
Family violence	<ul style="list-style-type: none"> • affects some of the other priority areas (1 general / health interviewee) • how is family violence defined? (1 general / health interviewee)
Crime prevention	<ul style="list-style-type: none"> • already has a lot going on (1 general / health interviewee)
Injury prevention	<ul style="list-style-type: none"> • covers some of the other priority areas (2 general / health interviewees) • what it covers (e.g. injury prevention at home) should be made clearer (1 general / health interviewee) • must include a self-harm / suicide prevention focus (1 stakeholder) • the goal of 'a positive safety culture' is not strong enough as it stands – it sounds like it is just about raising awareness (1 stakeholder)
Road safety	<ul style="list-style-type: none"> • road safety programmes are the most successful, so they need to keep going (1 general / health interviewee) • links into what the other areas are achieving (1 general / health interviewee)
Workplace safety	<ul style="list-style-type: none"> • workplace injuries have social and serious consequences (1 general / health interviewee) • not everyone is at work, so it is a lesser priority (1 general / health interviewee)
Emergency management	<ul style="list-style-type: none"> • some might query why emergency response needs to be in there, but it needs to be a priority because the Canterbury earthquakes and the tsunami in Japan have 'become part of the New Zealand psyche' (1 stakeholder) • 'we live under a mountain [volcano] so maybe emergency response should be the number one priority' (1 stakeholder) • it is already well covered – is there a gap? (1 general / health interviewee) • not sure it should be included, but it is about safety (1 general / health interviewee) • high consequence but low incidence – it is after the event rather than prevention, but could prevent more serious consequences (1 general / health interviewee) • it is a slightly different category to the others (1 general / health interviewee)
Secure and Healthy Homes	<ul style="list-style-type: none"> • I see the merit in it, but should it be driven at a national level, rather than locally? (1 general / health interviewee) • a bit different from the other priorities (1 general / health interviewee)

Areas that should not be included as priorities

The interviewees were also asked if they thought any of the eight areas should be excluded from the strategy. One stakeholder and one general / health interviewee thought that crime prevention should be excluded, with one of these people saying that crimes do not necessarily lead to injury. Two other stakeholders thought that Secure and Healthy Homes should not be included, again because it is not injury-focused. Another stakeholder suggested that Emergency Management should be excluded because it is not a day-to-day issue.

Suggested additional priority areas

The most common additional area that interviewees identified as being needed in the Community Safety Strategy was safety for Māori. Two stakeholders said Māori were 'noticably absent from the strategy – no strong theme or statement anywhere'. Also, a general / health interviewee said that iwi should be making decisions about the strategy, but there was no Māori representative on NPIS at the time the strategy was written.

Two general health interviewees suggested that sports and recreation should be included, again maybe across other priority areas rather than as a separate priority area. There were similar comments about falls and schools (1 general / health interviewee).

One stakeholder suggested 'older people' should be a priority as 'so many get injured at home and they are a growing population'. Another stakeholder said that child safety should be a priority – 'we merely assumed the goals will cover them'.

Strategic goals

One general / health interviewee liked the strategic goals and believed that they 'reflect solid and applied thinking'. Another said the strategic goals were 'fine'.

However, another general / health interviewee thought the strategic goals were 'too wordy' and said a strategic plan should be able to be read by anyone. Another general / health interviewee said that the goals are 'words rather than action'. She thought the strategy was bogged down in processes rather than outcomes and that her 'eyes tended to glaze over' with this type of document. Another general / health interviewee said 'while the strategic goals are understandable, they are action-focused rather than goal-focused. They need to be reworded so they reflect outcomes. The strategy needs to join the dots'.

Several people thought the strategic goals should mention Māori specifically. One general / health interviewee suggested that 'tangata whenua vision and participation should be overarching at all levels across all the strategic goals.' This person said that the strategic goals need Māori participation and collaboration.

There were a number of comments about the second and third strategic goals which are, respectively:

- 'long-term, sustainable programmes covering both genders and all ages, environments and situations'; and
- 'programmes that target high-risk groups and environments, and programmes that promote safety for vulnerable groups'

One general / health interviewee thought that these two goals could be in conflict with one another, and they need to be worked through a bit more. The roles and responsibilities of key agencies also need to be understood and be clear – for example, who is responsible for implementation of the New Zealand Injury Prevention Strategy now?

One general / health interviewee thought the second strategic goal was good – you have to have long-term sustainable programmes and you have to target high-risk groups. However, you need to have programmes where outcomes can be measured and that are proven to be effective. Four stakeholders suggested this strategic goal was 'too broad' or 'too general as it stands'. 'Does it cover all ethnicities and age groups?' asked one.

All four of the above stakeholders were concerned that unless the high- risk groups are specified in the third strategic goal (Māori, children, older people) there was a risk they would not be given the attention they deserved. A general / health interviewee suggested that the high-risk groups should be specified as: people with chronic disabilities unable to access care, Māori and Pacific Islands people, and people from low [socioeconomic] deciles.

Other comments about the strategic goals included:

- they are a duplication of the NPDC's 'alcohol' strategy (1 stakeholder)
- an agreement that the fifth goal relating to evaluation measures is needed - evaluations are useful and should be done (1 general / health interviewee).

Additional comments

At the end of the interviews, people were invited to make further comments about the topics already discussed throughout the interview, or about any related issues.

New Plymouth community

Several interviewees emphasised that New Plymouth is a very suitable context for community injury prevention activities to be successful. One general / health interviewee said 'the community is quite a positive community generally.' There are good community leaders and people are 'proud to live here'. Another suggested that New Plymouth is a good size.

Another general / health interviewee said that New Plymouth is in a unique position as a provincial city with a high urban population and a high proportion of manual workers. It also has a rural

environment with surf and the mountain. As far as community safety goes, this setting is beneficial as well as posing some challenges.

Preventing injuries

Educating people about reducing injury is important, according to two of the general / health interviewees. One said that we need to educate children from an early age.

Another general / health interviewee emphasised the importance of physical activity programmes, and prevention programmes for patients who were hospitalised for injury. She also emphasised the importance of reporting injuries and initiating programmes in order to get positive outcomes.

One general / health interviewee said that New Zealand is a risky place. She said that the essential point is that injury is related to risk. She believed people make decisions and we can't fix human behaviour, although people should use the right equipment when engaging in risky activities.

Another person said that a lot of good work is being done on preventing injuries among farmers – this needs to continue.

NPiS programme manager

Four of the general / health interviewees again mentioned the current lack of an NPiS programme manager. One commented that Channa had made a difference and it had been great to have someone of that calibre. She said it is necessary to have a programme manager, and leadership is required.

Another interviewee said that since there has been no programme co-ordinator, their organisation has had no meetings or communication with NPiS.

While another interviewee had not noticed much difference since the programme manager left, he believed now it is not clear who is in the lead, or who is the contact person. He added that having a person focusing entirely on an issue (i.e. a co-ordinator or programme manager) is generally effective.

A further general / health interviewee commented that since Channa left, it has not been possible to have someone representing NPiS or the Safe Community at meetings – there is no operational officer. He believed the presence and awareness [of NPiS / the Safe Community] has decreased in some areas. However, while there have been 'obvious strains at the administrative level' he was not sure that the general community would have noticed any difference.

Resources and funding priorities

Two general / health interviewees mentioned the difficulty NPiS / the Safe Community has had since ACC withdrew its funding for the co-ordinator. Related to this, one person was concerned that if the brief for NPiS / the Safe Community became too broad, current funders might be

reluctant to continue their funding. For example, if there is too much of a focus on crime prevention, injury-related funders like ACC may be reluctant to continue even their present level of support.

She added that the removal of injury from the list of national health priorities also means that government-funded health agencies have more difficulty justifying spending on injury prevention at the local level. She said it is not impossible, but it is a barrier: it is not an 'enabler'.

NPiS / Safe Community branding

One general / health interviewee mentioned the confusion that exists in NPiS / Safe Community branding. For example, on the newsletter, there is the NPiS logo, but not on the Safe Community website.

Community safety strategy

Extra comments relating to the community safety strategy included:

- the priority areas should be based on need, inequalities and the ability to do something (effective intervention) (1 general / health interviewee)
- the priority areas are intertwined (1 general / health interviewee)
- it is good to have Secure and Healthy Homes as a priority – leads to better health and well being 'whānau ora' (1 general / health interviewee).

Other comments

- there should be an NPiS equivalent across New Zealand (1 stakeholder)
- 'I've no time for creating things for the sake of creating them... needs to be activity focused' (1 stakeholder)
- NPiS should ensure that all programmes under its umbrella include a strong focus on measurable outcomes for accountability purposes (1 stakeholder)
- NPiS should look at the injury prevention / safe community work done in Wanganui (1 stakeholder)
- NPiS should keep up with the accreditation requirements 'having alcohol and crime prevention in there will help towards this' (1 stakeholder)
- there is a strong relationship between Be Safe Taranaki and NPiS (1 stakeholder).

12

MĀORI FOCUS GROUP

Community consultation for the needs assessment also included holding two special-interest focus groups. The first of these was a focus group for Māori participants to discuss their perspectives on injury and safety issues.³⁶ This focus group was held on 8 February 2012 at Tui Ora Limited at the Maru Wehi complex in Westown, New Plymouth.

Tui Ora organised and invited eight people to participate in the focus group. Three of the eight were unable to attend on the day. The five who participated included three Tui Ora staff members. The participants were:³⁷

- a primary health care *kaiāwhina* and cancer services navigator (Tui Ora)
- a mental health employment services advisor (Tui Ora)
- an injury prevention health promoter who supports parents and their pēpe (babies) (Tui Ora)
- a sports education academy co-ordinator and personal trainer
- a general practice outreach practice nurse.

The group discussion was facilitated by Caroline Maskill, assisted by her research team colleague Velma McClellan. The representative of Tui Ora who had arranged the focus group (Lyn Hoskin) introduced the session and led a karakia at the beginning and end. The focus group facilitator then 'set the scene' by outlining the purpose of the focus group workshop and explaining the structure of the two-hour focus group session (10:30-12:30am), which included two short breaks, and was followed by lunch.³⁸

³⁶ The second focus group was for people involved in the field of workplace safety and employment. Results from this group are presented in chapter 13.

³⁷ A list of consultation participants is provided at the end of this report.

³⁸ See chapter 1 for more detail on the design and running of the community consultation focus groups.

Most concerning injury and safety issues

The five focus group participants indicated that all the injury and safety issues they raised throughout the focus group were provided from a Māori perspective. Current issues that most concerned them were:

- **Water safety** – lots of deaths (drowning) and injuries.
- **Road-related injuries** –
 - there have been two recent fatalities in black spots – Waingona Bridge through to Brixton where road seal issues exist
 - Taranaki drivers were described as ‘wicked’/‘ruthless’ and generally lacked courtesy, particularly with regard to cyclists
 - some ignorance around the Road Code, for example crossing over into far lanes at intersections, incorrect indicating of direction of turn, or not indicating at all
 - running red lights – most notorious lights – Fitzroy lights by Domino’s Pizza retail outlet and Hobson Street intersection on to the one-way system. However all intersections on the one-way traffic system are potentially hazardous
 - drink-driving by high-risk groups (teenagers, middle-aged, unemployed, single parents)
 - ‘lots of texting’ from one side of town ahead to warn mates of Police presence ahead
 - lots of drinking at home (it’s cheaper to drink there), then get out and drive
 - cars are often unregistered
 - driving long distances for work and not stopping for breaks.
- **Family violence** – is exacerbated by a culture of alcohol and drugs in the home.

The focus-group participants listed the following safety-related issues that they believed are getting worse now, or will become more significant in the future:

- **Fighting** –
 - fighting-related injuries – ‘it’s got so bad that it has become normalised’/ even use cars to crash into each other/ again fuelled by alcohol and drug abuse
 - is particularly bad at weekends
 - largely involves young people but not exclusively; they tend to gather in big groups; girls are involved in fighting too
 - includes some ‘lighter fluid’ sniffers / users
 - City Council car parks are a common place for fighting – car parks are ‘free’ therefore accessible for big groups to congregate
 - sometimes young people turn up to their weekday commitments on Mondays with black eyes from fighting at the weekend.

- **Child neglect and abuse –**
 - lots of Child Youth and Family Services referrals resulting from caregivers' poor parenting skills, e.g. inappropriate disciplining, domestic financial issues that lead to 'hungry children', lack of after-school supervision, burns and scalds from hot water, sunburn
 - high injury risk for children/ toddler injuries in rurally-isolated and farming homes, where largely uneducated parents provide limited or no supervision for their children – falls occur during unsupervised climbing, children riding cycles or ATVs when they are 'too young' to do so, parents' judgement or expectations about the child's skills are unrealistic
 - children left alone in unsafe environments while parents are working
 - working parents who are too tired to parent / monitor their children activities properly when they come home from work.
- **Child day-care accidents –** possible injury risk for children when doing some craft activities e.g. hammering nails.
- **Older people –** have a high risk of falls.
- **Sports injuries –**
 - knee injuries are a common issue 'across the board for all sports'.
 - recreational sport injuries – for example 'whānau fun days' / 'touch rugby' – some people are lacking in fitness for these, and therefore are prone to injury
 - gym-related injuries – these have recently featured in local newspaper / backed up by 'lots of ACC claims'. A particular issue 'in the new 24-hour gyms'. Three gyms have opened up in the past three to six months and most do not provide professional staff supervision outside usual business hours. People are attracted to these gyms because able to use on a casual basis (long-term contracts are not required).
- **Work-related injuries –** workers in sedentary jobs, especially older workers, are prone to 'bad backs', knee and muscle problems and repetitive strain injuries as a result of not stopping for breaks.

Addressing injury prevention and safety issues

The focus group participants were shown a copy of the report *Poututangata: Māori and Injury Community Action Research* (New Plymouth Injury Safe 2008), prepared by the Poututangata Māori and Injury Community Action Research Group. They were asked whether they agreed with the report's four principles of action – self-responsibility, injury prevention education, appropriate service provision and improved housing conditions – as ways to reduce injury among Taranaki Māori. They were also asked if there were any additional relevant themes they thought could be useful.

A brief discussion resulted. In general participants considered three of the themes remained relevant, namely family violence and child neglect related services, as well as primary health care services such as Piki Te Ora. All three were said to be provided, to a limited extent, through some existing Māori services. However, the home-safety improvements formerly provided through the Waitara-based WISE housing environmental improvement programme were reportedly 'no longer happening'. It was suggested that this was because ACC withdrew the funding for this component of the WISE programme.

The participants did not identify any additional themes relevant to addressing injury prevention and safety issues.

Local initiatives/ programmes currently addressing issues for Māori

In general, this discussion gave the impression that very little was happening in the way of Māori injury and safety-specific initiatives/ programmes since Tui Ora's Matiu Julian, the former New Plymouth injury Safe (NPiS) member, left the district to take up a job in Wellington. Programmes / initiatives that participants identified, and their related comments about these, were as follows:

- The primary health care **Piki Te Ora** nursing service
- **KidSafe Taranaki** – although this was seen to be much less active than it had been in the past, and is somewhat dependent on one particular member, namely its ACC representative, Kath Forde.
- **Car seat education** – though identified by participants, no one was particularly sure if this work was still happening.
- **Child restraints education and support** – Plunket reportedly provided this support role at one time but parents were expected to go online to access help. Some reportedly come up to Tui Ora for help but no one specific person is there available to help. There is also the problem that new models of restraints are regularly coming on to the market.
- Tui Ora's **defensive driving** programme – is a one-off, not a regular event.
- **De-escalation** training for mental health workers to calm down violent clients.
- Tu Tama Wāhine – **family violence prevention support and training** – provides home-based, working with families and school-based programmes (piloted in Waitara).
- **Training on the use of gym equipment** – gym clients not paying for personal training and use of equipment are usually given 'just a quick run through on how to use the equipment'. This means they are prone to injuries through incorrect use of equipment – it was suggested everyone needs a specific session on using the various types of equipment available.
- **Sports club coaching** – very few local clubs fund / provide sports safety training for their coaches.
- **Whānau Day** – a well-attended event sponsored by Tui Ora in November 2011 – included lots of health education tents, displays and fun events – a self-completed survey on the day showed that many parents who completed the survey did not know about 'booster seats'

and the use of 'door latches' to prevent children from accessing medicines and other potential household poisons.

New Plymouth injury Safe and the Safe Community

Two of the five focus-group participants were aware of NPiS prior to having received the focus group's background information. Three knew of the New Plymouth Safe Community programme prior to having received the session information.

Participants were also asked to what degree NPiS / Safe Community initiative contributed to the district's injury prevention and safety issues, and the value these added to the work of other agencies working in the area? One participant, familiar with the work of NPiS, considered NPiS did add value at the strategic level, and noted that Tui Ora is a member of the NPiS Trust group. However, the other focus-group participants did not know enough about NPiS or the Safe Community to make any further comments on their impact or value.

Addressing gaps in Māori injury prevention / safety issues

The focus group participants were given a large sheet of white paper and pens and asked to work as a group to establish what they considered were (1) the main gaps and barriers locally to addressing Māori injury prevention/ safety issues (2) who they considered should deal with the issues and how, and (3) how NPiS could help or support Māori to deal with these issues (if anything). Table 12.1 below presents the group's written output outlining their views and ideas on these questions.

Table 12.1

Gaps in addressing injury prevention and safety issues for local Māori

Main gaps and barriers in addressing injury and safety issues	Who should deal with these and how?	How can NPiS do more to help or support other groups to deal with these issues?
Lack of strategic direction for Māori on draft strategic plan	New Plymouth injury Safe New Plymouth District Council	Top priority / urgent
Lack of financial resources	Ministry of Health	
Key community workers for Māori	Tui Ora	Regular meetings Relevant representatives
Education and information		More promotion to community/ networks
Management <ul style="list-style-type: none"> - Time away for staff - communications 		
Whānau	Key community workers / other community services	Provide support for

The Poututangata report's recommendations

Poututangata: Māori and Injury Community Action Research (New Plymouth Injury Safe 2008) made three recommendations for progressing Māori injury prevention in Taranaki, these being:

1. Increase the Māori injury prevention workforce
2. Develop a strategic direction and plan for Māori injury prevention
3. Set up Poututangata umbrella group representing Māori injury prevention in Taranaki.

The needs assessment focus-group participants were asked to comment on how far these recommendations had progressed since 2008 and whether the recommendations remained appropriate today.

The two participants who were familiar with the Poututangata report reported that no progress had been made with regards to the three recommendations. If anything, the situation was considered to have worsened given there 'was no one to drive it' since Tui Ora's Māori Injury Prevention Coordinator had left that position.

While Tui Ora reportedly does currently employ a part-time health promoter who deals with injury prevention alongside the Mums and Pepi service which is one-to-one and client-based. Overall planning and co-ordinating of Māori-focused injury prevention activities that occurred prior to 2011 reportedly no longer happen. The focus group described injury prevention as a relatively low priority for local Māori services.

The participants generally saw no real need for a separate Māori group, parallel to NPiS, to lead the community response to Māori injury prevention and safety issues. Rather they considered there was a need for 'someone' to be appointed to a community-orientated role within Tui Ora. They believed the person appointed should have strong 'grass roots connections' and the knowledge and experience in terms of kaupapa Māori with respect to injury prevention and safety issues. There was some hope within the group that the recently vacated Māori injury prevention coordinator's role would be re-established once the planning, development and implementation of Tui Ora's proposed Whānau Ora Centre is completed.

Community safety strategy

The participants thought the community safety strategy was a good idea, but also saw a need for a Māori-specific strategic plan to address injury prevention and safety issues that are relevant to Māori. They said Māori-specific approaches would need to be developed and tailored to meet Māori needs, hence the need for a Māori-specific plan. The group believed Māori injury and safety issues would be better expanded to Taranaki as a whole, but acknowledged there were differences between the north and south regions, which would require approaches specific to each region.

One participant saw a need to have appropriate Māori representatives, and an 'action plan' for each of the draft strategy's eight programme response / priority areas.

The group queried what Māori input had gone into developing the draft strategy to date. The draft was seen as deficient in having not used any common Māori concepts and wording, such as 'whānau / family'. However, the participants commended NPIS for having put the draft out for consultation and were pleased to have been given the opportunity to provide input into it.

13

WORKPLACE FOCUS GROUP

As part of the community consultation for the needs assessment, a special-interest focus group discussion on workplace safety was held at the Be Safe Taranaki Centre at the beginning of February 2012. The seven participants in the focus group came from the following industries:

- farming / agriculture
- electrical trades
- care of the elderly
- construction
- oil and gas
- food processing.

Most of the participants were advisors or managers with a responsibility for or interest in health and safety issues or quality assurance (a list of consultation participants is provided at the end of this report).³⁹

Current injury and safety issues

Focus group participants were asked to identify the most important / significant work-related injury and safety issues in New Plymouth District that exist currently.⁴⁰

Safety training

A number of comments indicated the focus group participants' opinions about the safety training of workers, including:

³⁹ For more details about the focus group methods, see the Introduction.

⁴⁰ For anonymity reasons we have not specified which industries each issue applies to, and for practical reasons mostly we did not attempt to record the number of participants agreeing with each issue.

- a lack of training / awareness among young workers – they don't have an ethos of health and safety, and are not trained adequately in safety; they do not know the basics and can't see / recognise hazards or pre-empt them
- employers expect new workers to be trained in health and safety issues already, and do not provide them with training on the job – especially small employers
- some computer-based training that is provided is not adequate; face-to-face / classroom training is more effective
- there has been removal of safety training courses due to funding cuts e.g. Farmsafe courses
- some workers are reluctant to participate in safety training.

Job fitness

There was general agreement among the focus group participants that workers are not always up to the physical or mental demands of their jobs, putting them at risk of injury or other harm. These opinions included:

- young workers often are not used to working manually and some don't want to work
- people who are unable to cope with 8 hours per day / 40 hours of physical work per week get repetitive strain injuries – they need to be started off slowly and gradually increase hours, a 3-month trial period of employment helps with this issue
- older workers (50+) doing physical work need lighter work at the end of their careers, they also find change hard
- when there is a boom in an industry, employers have to take on less experienced, less well-trained workers.

Workforce diversity

A high level of diversity within some workforces also leads to safety risks. This includes a wide range of staff ages (e.g. from ages 18 to 70) and a wide range of disciplines, all of whom have to be accommodated.

Hazards relating to particular jobs

Some hazards identified by the focus group related to specific jobs, such as:

- 'ATVs' (quadbikes), tractors, chemicals
- injuries from having to manually handle clients e.g. back injuries from lifting
- elderly clients with mobility and sensory impairments – they are prone to falls entering and exiting the premises, falls from beds, using mobility scooters and walkers, they are frailer sicker now because they stay in own homes longer than they used to
- aggressive customers who have been smoking / drinking
- staff working alone with no supervision e.g. in jobs that involve visiting clients / customers at home.

Other work-related issues

Other identified injury / safety issues that relate to activities at work and the workplace environment include:

- staff who do not comply with safety regulations / good practice
- staff being distracted from work by cell phone use
- the need to have caring workplace culture / environment – knowing your workers will help to create a safe workplace.

Wider issues from outside work

The focus group also described a number of injury and safety issues that occur outside the workplace but affect people when they are at work. These included the following health and lifestyle issues:

- health issues among older workers e.g. prostate cancer
- physical injury / health issues not declared by staff on job applications / ACC forms
- undeclared mental health issues, stress, cognitive capabilities (e.g. when older)
- contract staff not having been screened (as employers expect) for injuries / illnesses / medication use
- alcohol and drug use (prescription and illegal) – some workplaces have drug testing regimes but not all target drugs other than alcohol and marijuana, they do not detect use of party pills, methamphetamine (P) or caffeine / energy drinks
- fatigue – some young people stay up very late or all night to party; other staff do private work outside main employment or a lot of overtime work; many people lack a good work-life balance e.g. having to work as well as look after children and housework.

There has also been a recent reduction in ACC subsidies for physiotherapy treatment, leading to some workers not getting adequate treatment for injuries.

In addition, the focus group said that some workers' poor economic circumstances mean they want to work when they have injuries or health problems so they do not lose pay, but working with these conditions can be a safety risk.

There are also some local environmental hazards causing injury to people in non-work time such as broken glass on footpaths and roads, glass-based paint in cycle lanes that damages road cycle tyres and unsafe footpaths.

Future injury and safety issues

The focus group participants were also asked if there were any additional injury or safety issues that were likely to become more important / significant to workplaces in New Plymouth District in the future. As a prompt, they were given the list of future issues identified in the *NZ Workplace Health and Safety Strategy to 2015* (Dyson 2005a). These issues were: changes in work and society; growth in precarious employment; emerging illnesses; more small and medium workplaces; and increasing workforce diversity. The focus group generally agreed that these issues applied to the local area, and also identified:

- language and cultural barriers when trying to communicate with new-immigrant workers about safety issues and training e.g. it is hard to know if they have understood safety messages because they are reluctant to say they don't understand
- people working from home on computers in mental and physical isolation
- elderly clients increasingly being looked after in own homes, so carers will be working unsupervised, and clients will be on their own more of the time
- more allergies to chemicals, food
- changes in diet – people eating more fast food meaning they are less healthy
- more sports injuries
- the ageing population who have to look after large gardens at home may be more prone to injury, on the other hand may stay fitter because of the exercise.

Addressing workplace injury and safety issues

The focus group split into two sub-groups to participate in a group exercise to identify local gaps in addressing workplace injury and safety issues.⁴¹ Table 13.1 below shows the results of the exercise (the suggestions from the two sub-groups are combined).

⁴¹ Because of the time it took the group to answer questions 1 and 2 of the focus group schedule, question 3 was not asked ('what local initiatives / programmes / groups / coalitions are currently addressing workplace injury and other safety issues in New Plymouth District').

Table 13.1

Gaps in addressing workplace injury and safety issues

Main gaps and barriers in addressing workplace injury and safety issues	Who should deal with these and how?	How can NPiS do more to help or support other groups to deal with these issues?
<p>Behaviour / attitudes to health and safety from workers and management – e.g. recidivist behaviour, corner-cutting</p> <p>Macho approach – workers going to work with injuries</p> <p>Non-reporting of incidents</p> <p>Non-compliance in attending training</p> <p>Money for training drying up</p> <p>Economics – limited resources available in the workplace and workers needing to attend work because they need money</p> <p>Knowing where to access training and training material</p> <p>Training needs to be creative and interesting, using fresh material</p> <p>Bringing problems from home to work</p> <p>Bringing contaminants (e.g. chemicals) from work to home</p> <p>Lack of rehabilitation</p> <p>Lack of skilled workers – not good at the '3 Rs', tend to use text language</p> <p>Language barriers</p> <p>Cultural differences because of multi-ethnic workforce</p>	<p>Individuals / workers themselves</p> <p>Employers - management and systems</p> <p>Employers giving employees incentives to keep healthy – could give workers gym memberships, health checks, immunisations</p> <p>Early education – high schools need to teach some health and safety training e.g. through horticulture course, work experience</p> <p>More health and safety training during vocational courses</p>	<p>Community-based discussion and support groups (direct person-to-person support) involving all sectors</p> <p>Provide information on how to access support from NPiS or others e.g. provide a directory of services including specialist organisations</p> <p>More health and safety education</p> <p>Hold workshops</p> <p>Help people to improve life [-work] balance</p> <p>Not sure who funds NPiS – needs to be visible as a resource</p>

Awareness of NPiS and suggested improvements

Before they started the exercise described above, participants were asked about their awareness of NPiS and the New Plymouth Safe Community. All participants had heard of NPiS, often through the newsletter. However, only one person previously had heard of New Plymouth Safe Community.

The focus group participants were asked also if they had any further suggestions, not already covered, for improvements to NPiS.⁴²

The group wanted an extended description of what NPiS does, as most of them were unsure about this. Even after the explanation, most felt unable to make many suggestions for other improvements to NPiS. One person commented ‘We don’t know enough about them. We now know their background and that these things happen ... but actually getting their branding and what they actually do for the rest of the community is the issue... [NPiS] as an organisation – we don’t understand it fully’. They also suggested that NPiS had a lack of visibility.

A few participants speculated that currently there may be an imbalance (not enough) in the amount of NPiS’s budget going to administration, because of the lack of a co-ordinator / programme manager.

Community safety strategy

Members of the focus group had already been given the draft community safety strategy to look at before the focus group session (see appendix volume two for a copy of this).

All agreed that it is a good idea to have a community safety strategy. One said ‘it’s imperative’.

Simplicity vs. wordiness

One person commented that the previous document *New Plymouth Safe and Secure Community Strategy* (New Plymouth District Council / Safe Community Strategy Group 2010) was extremely long and loquacious, which probably accounted for the lack of feedback on it. She said that people want something simple, and the latest document is wordy and could be simpler, particularly the first diagram (on page 2). Several other participants agreed with this.

Another participant said ‘You just want people to buy into it. [Increase the] visibility. Get the message out and keep it simple. Then people will buy into it.’ He said he picked the document up and put it back down again because it was too wordy.

⁴² As only one person had heard of the Safe Community we did not ask them about improvements to the Safe Community, as originally intended.

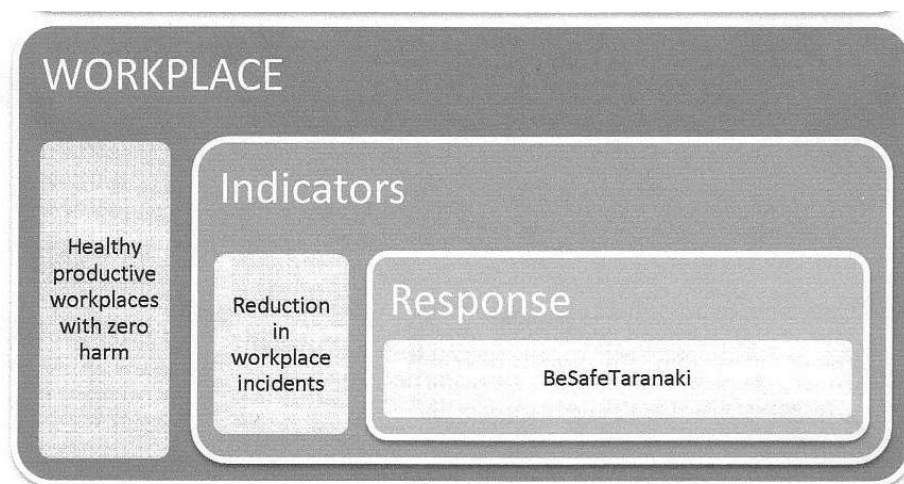
One person thought the draft strategy is laid out very well but the actual words could be simpler – he had to concentrate hard to read it.

‘Response’

One member of the focus group said the strategy was just describing what was already happening and not what needed to be done. According to another participant ‘It’s the same old same old, but what should we actually do about it?’

In particular, the boxes labelled ‘response’ seem to be referring to existing groups. People were not sure this was appropriate, and maybe ‘response’ was the wrong label for these boxes. They suggested it should be labelled ‘lead group’ or ‘lead organisation’.

Comments on the detailed workplace programme response



Several members of the focus group thought the term ‘zero harm’ is inappropriate for the goal relating to the draft workplace programme response (see diagram above). Some focus group members thought that ‘zero tolerance’ would be a better term.

However, another participant disagreed and said it is not realistic or desirable to aim for no harm at all. He believed that people need to learn to deal with risk and it is inevitable there will be a few injuries while people are learning – some harm has to be tolerated. He said that you can’t take away all risk – ‘you may as well go home and sit in cotton wool’. A further participant said that you want people to take calculated decisions regarding risk. However, one focus group member was quite happy with the term ‘zero harm’.

After further discussion, the group agreed the goal should be ‘healthy productive workplaces’ without mentioning ‘zero harm’.

Most were satisfied with the wording of the indicator 'reduction in workplace incidents' as it is self-explanatory. However, one participant thought it should be phrased more positively, for example 'improving the workplace environment'.

Again, the group did not like the label 'response' in the inner box of the diagram, and said that most people would not know what 'Be Safe Taranaki' means. One participant said 'It means nothing to most businesses, because other than the newsletter, you don't actually see or hear from them... It's not Be Safe that's going to end up creating healthy productive workplaces, it's the workplaces themselves.' Another added that it was the culture or ethos of each workplace that is important.

Other focus group members said that Be Safe Taranaki is only a small part of the local effort to reduce injuries – each workplace has its own initiatives in place to do this. They thought the 'response' should not rely on a subsidised group, it is something people in workplaces should be doing themselves.

On the other hand, another focus group member said that Be Safe Taranaki currently is trying to raise its profile, and a lot of the training takes place there.

14

DISCUSSION AND CONCLUSIONS

This final chapter discusses the study's main findings and conclusions.

Features of New Plymouth District injury and safety statistics

With three needs assessment studies now completed, an extended set of New Plymouth District injury statistics is available stretching back more than 20 years for some datasets. This is a major resource for examining injury patterns and use of injury-related care and treatment services in the district, including the extent to which these have altered over time. It also provides a basis for forecasting which types of injury and safety issues, for which population groups, are likely to continue to be important in the years ahead.

Injury deaths

Looking first at injury deaths, since these are arguably the most extreme and undesirable outcome of injury events; in the five years from 2004–2008 (the latest year for which mortality data is available) on average 31 New Plymouth District people died per year as a result of injury.

Looking at injury deaths over time, age-standardised injury death rates for the district (calculated as 3-year running averages) progressively fell in the nine years from 2000–2008. In addition, New Plymouth's rates (as 3-year running averages) were largely below New Zealand's throughout this period, despite New Zealand's rates also falling.⁴³

Hospitalisations

Inpatient hospitalisation can be regarded as the second most undesirable or extreme outcome of being injured. Usually hospitalisation implies an injury event of some seriousness requiring treatment with specialised equipment and personnel. It may also involve a lengthy period of recovery or rehabilitation in hospital, at home or in some other facility. Such events typically involve major distress and disruption for the patient and people close to them, as well as

⁴³ Although the number of injury deaths averted may seem small, it should not be forgotten that economic analysis for the transport sector places a value of some NZ\$ 3.35 million on each individual human life (at June 2008 prices); what is technically referred to as 'value of statistical life' or VoSL (NZIPS Secretariat 2010: 10).

substantial direct dollar costs to the person and/or state for hospital and, in some cases, ongoing health or disability support services.

Over the five years 2006–2010, New Plymouth District people had an average total of 1,630 inpatient hospitalisations per year for injury. Looking at trends over time, while New Zealand's all-age injury hospitalisation rate has increased fairly steadily and consistently over the years from 1989 to 2010, New Plymouth's has either dropped or stayed relatively static until 2007. From 2008–2010 local injury hospitalisations increased, although they have still been lower than New Zealand's in every year except 2009.

Emergency department attendances

Hospital emergency department attendances for injury typically involve a mix of relatively minor, moderate and severe injury cases. Emergency department patients may or may not be subsequently admitted to inpatient hospital care, depending on the seriousness or complexity of the presenting injury and other factors such as bed-availability and whether the patient has family or friends to look after them at home. In 2010, New Plymouth District residents made a total of 7,666 visits to hospital emergency departments in Taranaki for injury treatment. As might be expected given population increases, this total is higher than that recorded in 2000 (6,531) and 2005 (7,249). Interestingly, though, in 2010 injury visits comprised just 31% of all emergency department visits that year (i.e. non-injury plus injury visits) whereas in 2000 and 2005 injury visits made up, respectively, 36% and 35% of all visits.

ACC entitlement claims

Some people with injuries treated in hospital emergency departments or as inpatients will submit accident insurance claims to ACC for entitlement payments. So, too, will some people with injuries treated by general practitioners, after-hours emergency services, specialist physicians and other health care professionals. In the eight financial years from 2000/01 to 2007/08, the number of accepted ACC new entitlement claims for New Plymouth District steadily increased, from a total of 1,829 in 2000/01 to a total of 2,400 in 2007/08. However, the two most recent years (2009/10 and 2010/11) have seen a notable reduction in the number of accepted new claims, the total dropping to 1,935 in 2010/11.

As also mentioned previously, it is important to be cautious when interpreting any data on injury based on ACC insurance claims, especially when seeking to trace injury trends over time, as insurance claims data can fluctuate simply because for example new policies are introduced defining who is or not eligible for entitlements. It should also be remembered that ACC entitlement claims data excludes the many thousands of people who receive one-off ACC payments to help cover the costs of medical treatment for injury.

The injury mountain

This last point is salient because it is a reminder that while mortality, hospitalisation and emergency department data are (and should be) central to any statistical analysis of injury and safety in New

Plymouth District, there are many other injury and safety-related events - albeit in most cases comparatively minor ones - that do not get recorded routinely on any database and are therefore not available for inclusion in a needs assessment such as this. These events comprise what might be termed the hidden dimension of the 'injury mountain' – the many thousands of injuries that people throughout the community experience in the course of a year, some of which are simply ignored or left to heal naturally, some of which are self-treated or treated by family or friends, and some of which are seen by health professionals such as general practitioners or physiotherapists but not deemed serious, complex or disabling enough to require emergency department or inpatient hospital treatment, or to trigger receipt of significant accident insurance entitlements.

Although no known data is available specifically on New Plymouth's hidden injury mountain, findings from research elsewhere in New Zealand and Australia can be used to develop a rough approximation of its likely size. In 2004 and 2005, the Australian Bureau of Statistics, in its National Health Survey, questioned a representative sample of the general all-age Australian population about their experiences and response to injury. Injury in this case was defined as: 'a trauma, poisoning or other condition of rapid onset to which factors and circumstances external to the person contributed significantly' (Australian Bureau of Statistics 2006: 1). Of the survey's findings, some of the most pertinent in terms of defining the size and nature of the 'injury mountain' were that:

- 18% of people had received one or more injuries in the previous four weeks
- 16% of the people who received an injury in the previous four weeks had visited a doctor or other health professional about the injury; 5% had visited a hospital
- 11% of people in the survey reported currently having a long term condition resulting from injury. The most commonly reported conditions were musculoskeletal conditions, which accounted for 25% of all long term conditions caused by injury.

Extrapolating these findings directly to the New Plymouth District population then, on the basis of the district's 2006 census population of 68,901:

- some 12,402 people (18%) will experience an injury at least once in a four-week period. This is the equivalent of 161,228 injury events a year; a conservative estimate as it excludes people who have more than one injury event in the four weeks
- of the 12,402 people injured in the four weeks, 1,984 (16%) will visit a doctor or other health professional about their injury. Extrapolated out, that is 25,797 health professional attendances for injury per year in New Plymouth District.
- of the 12,402 people injured in the four weeks, 620 (5%) will visit a hospital for treatment for the injury – this is the equivalent of 8,060 hospital treatments for injury a year in NPD. (As

noted previously, there were 7,666 actual emergency department attendances for injury in 2010 for NPD residents.)⁴⁴

- Of the total 68,901 NPD population, 7,579 (11%) could be expected to report having a long term condition resulting from injury. For people aged 15 and over, a quarter of these conditions are likely to be musculoskeletal conditions.

Emergency departments are typically the first place people go or are taken to when seeking any kind of hospital treatment for acute injury, so even injury cases later coded as inpatient hospital admissions are likely to have been first treated in a hospital's emergency department.

A couple of further general estimates can be calculated based on a New Zealand population survey that found 'just over' 40% of respondents had someone in their household who had received a medically-treated injury in the previous year (Hooper et al. 2003: 45). Assuming the figure of 40% is also true for New Plymouth District's 26,508 households (as at the 2006 census), this suggests every year a minimum of just over 10,600 households in the district have at least one person in them who gets injured one or more times and requires medical treatment.

Based on these actual and estimated totals, Figure 14.1 overleaf provides a general picture of the likely annual incidence of injury events in New Plymouth District including the usually hidden portion of the injury mountain.

Note that these estimates focus on mainstream health definitions of injury. These tend to classify injury as essentially some kind of observable *physical* damage to the person. Episodes of emotional or psychic discomfort, distress or pain, in the absence of observable physical signs of damage by an external mechanism or force, may not typically be counted as injury events. This is perhaps an interesting point to ponder in the context of discussion elsewhere in this document about the place of broader safety themes in community injury prevention projects, such as those relating to the people feeling safe in their homes at night or safe while walking city streets.

Types and causes of injury in New Plymouth District

Little direct evidence is available on the nature or causes of the many thousands of injury events occurring in New Plymouth District every year that do not get treated by a health professional. However, again the Australian Health Survey is instructive here. It found that more than one quarter (28%) of all injuries received by people in the community were cuts, and almost another quarter (21%) were the result of falls from a height of a metre or less (Australian Bureau of Statistics 2006). Cuts and falls therefore comprised almost half (49%) of all injuries received by people in the community at a given time. In terms of the place or location where injuries occurred,

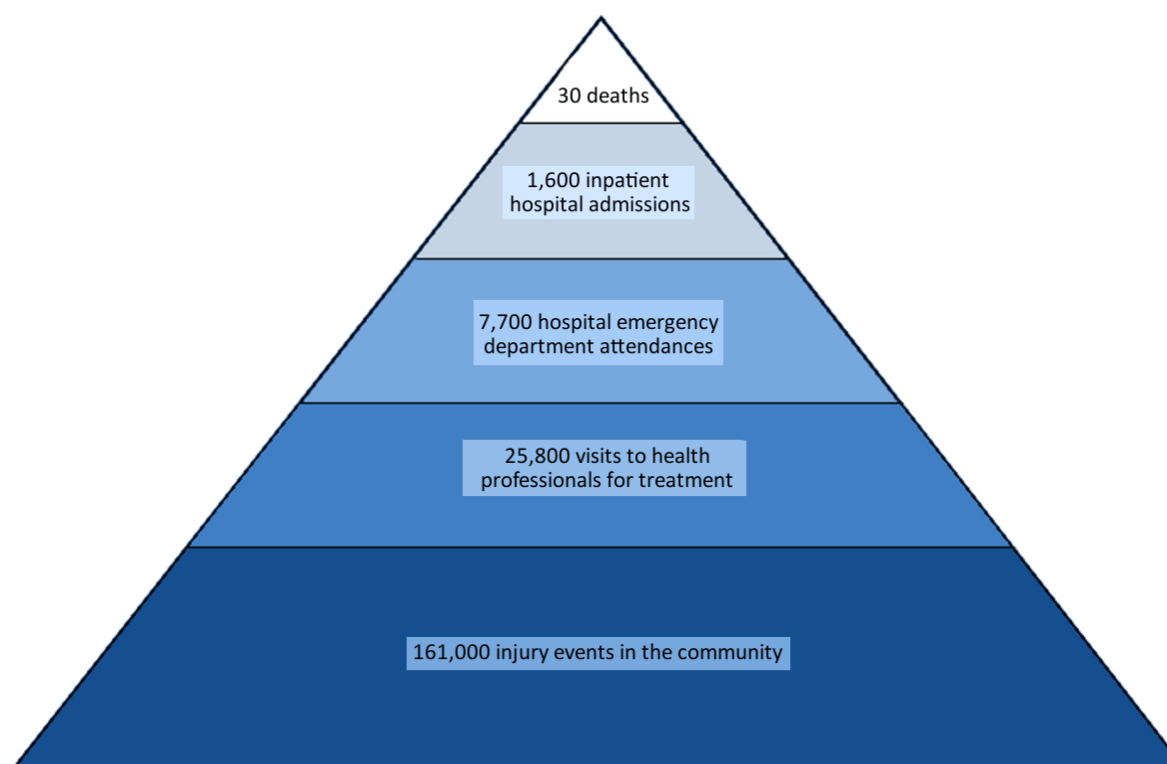
⁴⁴ Emergency departments are typically the first place people go or are taken to when seeking any kind of hospital treatment for acute injury, so even injury cases later coded as inpatient hospital admissions are likely to have been first treated in a hospital's emergency department.

the majority of injuries (55%) were received either inside (30%) or outside (25%) people's own home or someone else's home.

Extrapolated to New Plymouth, this amounts to a total of 45,144 cut injuries and 33,858 fall injuries a year. As indicated above, only a small percentage of these cut and fall injuries, perhaps something in the order of 16%, would be serious enough to require a visit to a general practitioner, hospital or other health service.

Figure 14.1

Estimated Total Injury Events and Treatments Over 12 Months New Plymouth District



Source: Estimates calculated by HealthSearch Ltd. based on data from Australian Bureau of Statistics (2006) and data supplied by Ministry of Health and Taranaki District Health Board.
Diagram is not to scale.

A little more is known about the injury events treated in Taranaki hospital emergency departments. Roughly speaking, these comprise about 5% of all injury events in the district. In 2010, approximately 58% of New Plymouth District emergency department visits for injury were coded to a specific cause or 'mechanism' for the injury. The causes of the remaining 42% of visits were coded to the category 'other' (although this is unlikely to be their true category in most cases, rather it suggests they simply have not been coded). While not ideal, the data in its current form is useful as a broad indicator of the categories of injury that tend to be seen at emergency departments. Injuries caused by blunt trauma (18% of all visits in 2010) and by falls (17%) are the two most common. Next come injuries caused by penetrating trauma (6%), strain (5%), a foreign body (3%), assault (2%) and overdose (1%).

More reliable information is available on the mechanisms underlying the injuries treated in inpatient hospital settings. This shows that falls are by far the most common reason New Plymouth people are hospitalised for injury (41% of all injury hospitalisations). The two next most common reasons are exposure to inanimate mechanical forces (15%) and transport accidents (14%). These are followed by intentional self-harm (6%), over-exertion, travel and privation (4%), exposure to animate mechanical forces (4%) and assault (3%). Intentional injuries (self-harm or assault injuries) make up 9% of all injury hospitalisations.

For the average 30 deaths a year from injury recorded for New Plymouth District residents, the three leading causes are intentional self-harm (29%), transport accidents (26%) and falls (23%). Together these three causes account for 78% of all injury deaths. Other notable causes are accidental poisoning by and exposure to noxious substances (5%), assault (5%) and accidental drowning and submersion (4%).

To sum up, falls feature significantly in not just the many thousands of everyday non-treated injury events occurring in the community, they are also a leading cause of the injuries seen in hospital emergency departments and the main cause of the injuries treated in day and inpatient hospital settings. As well, falls are one of the three leading causes of injury death for New Plymouth people.

While intentional self-harm features in just 6% of hospitalisations for injury, it is the leading cause of injury death (i.e. suicide), illustrating the extent to which a genuine intent to complete suicide, though rare, can be very final. Similarly, though transport accidents lead to just 14% of injury hospitalisations they are the cause of 26% of injury deaths, attesting to their relative 'deadliness'.

Trends in injury causes

Looking at trends over time for the different causes of injury, the best data to use for this is hospitalisation data as it is the most consistent and reliable. Mortality data numbers are too small to use and local emergency department data does not consistently code the causes of injury.

As chapter 4, showed earlier, over the 10 years 2001–2010, New Plymouth District's age-standardised fall injury hospitalisation rates were notably lower than New Zealand's, especially between 2004 and 2008.⁴⁵ Only in 2009 was New Plymouth's rate almost as high as New Zealand's. These trends suggest things have been happening in New Plymouth District in recent years that have made a favourable impact on hospitalisation rates for falls.

Looking more closely at fall injury hospitalisation rates by age helps to show which groups had the biggest rate reductions over this period.

For children aged 0–9, from 2001–2003 New Plymouth's rates were similar or slightly higher than New Zealand's, but from 2004–2008, New Plymouth's rates decreased and were considerably lower than New Zealand's. New Plymouth's rates increased again in 2009 to be almost the same as New Zealand's, before decreasing again in 2010 (see chapter 4 for details).

Looking at the older age groups, New Plymouth's rates of fall injury hospitalisations for people aged 80+ were consistently lower than New Zealand's throughout the ten year period. The same was almost the case for people aged 70–79, where New Plymouth's rates were lower than New Zealand's in every year but 2003.

A similar picture is evident for transport accident injury hospitalisations over this time. In every year up to and including 2008, New Plymouth's rates of traffic accident hospitalisations were lower than New Zealand's. New Plymouth's rate was higher than New Zealand's only in 2009. These findings are broadly consistent with the transport crash trend data examined in chapter 7 showing a generally downward trend in the number of serious or fatal road crashes and casualties in New Plymouth District over the period 1996 to 2010.

They are also consistent with the data for 2006–10 indicating New Plymouth District had a slightly lower proportion of road crash casualties with fatal or serious injuries (17%) compared with New Zealand and Group C areas (18% and 21% respectively). In addition, for the same period, 2006–10, the estimated average social cost of New Plymouth District injury road crashes was consistently lower than the Group C average and generally lower than the New Zealand average. Taken as a whole, these trends again suggest things have been happening in New Plymouth District in recent

⁴⁵ Detailed analysis of national injury statistics performed as part of evaluating the New Zealand Injury Prevention Strategy shows that New Zealand's all-age rates of serious, non-fatal injuries have been generally increasing from 1994 to 2008. Serious, non-fatal injuries are defined as injury events resulting in admission to hospital and associated with at least a 6 percent chance of death (about 13 percent of all injury-related hospital admissions fall into this category). The national increase in rates of serious, non-fatal injuries has been attributed to several possible factors including: effective injury prevention interventions that have reduced the severity of injury from fatal to serious; changing medical technology resulting in the increased survivability of previously fatal injuries; increased awareness and reporting of injurious events (e.g. as a result of the public campaigns encouraging the reporting of domestic violence and assault-related injuries); increased participation in physical and other activities associated with injury hazards (NZIPS Secretariat. 2010:12-14).

years that have made a favourable impact on road transport crash and casualty statistics, including traffic accident injury hospitalisation rates.

With the exception of 2009, rates of hospitalisation for injuries caused by exposure to inanimate mechanical forces were lower in New Plymouth than New Zealand throughout 2001–2010.

For hospitalisations resulting from intentional self-harm, New Plymouth's rates tracked either slightly below or alongside New Zealand's from 2001 to 2007 but above New Zealand's in 2009 and 2010. In the three and half years from July 2007 to December 2010, a total of 49 New Plymouth District people completed suicide. This was an average of 14 suicide deaths per year or approximately 1 suicide a month. More than half these suicides involved hanging (53%). Eighteen percent involved some type of firearm.

Types of population groups most likely to be injured

Turning now to look at which New Plymouth District population groups are most likely to feature in injury statistics, it is important to emphasise that there are two main ways of working out which groups to highlight.

The first is to consider the total number of injury cases in any given time period, say for example injury hospitalisations, and ask what kind of people or groups make up the largest share, or shares, of these hospitalisation cases. For example, in the five years 2006–2010, of the average 1,630 injury hospitalisations per year for New Plymouth District people, 896 were for males and 734 were for females. This indicates that males make up the largest share of injury hospitalisation cases (for details see chapter 4).

The second approach involves the principle of risk and ranks different population groups according to their statistical likelihood of getting injured or being treated for certain injuries. For example, even though New Plymouth District adults aged 80+ comprise only a small share of all injury hospitalisation cases, when looked at in terms of age-specific risk, that is the percentage New Plymouth District adults aged 80+ who get hospitalised for injury, this age group has a comparatively high risk of injury hospitalisation.

In the following discussion both methods are used to pinpoint population groups of interest, but with an emphasis on the risk approach.

As already mentioned, very little is known about the hidden mountain of New Plymouth District injuries that are not treated in hospital or cause death. This includes which age and gender groups are most likely to get these injuries. However, results from the Australian Health Survey show that children and young people aged 0–14 are the age group most likely to receive an injury, with 25% receiving an injury in the previous four weeks (males 24%, females 25%), compared with 18% of the all-age total population. The survey also found that people's chances of receiving an injury reduced with age, with just 10% of adults aged 65+ receiving an injury in the previous four weeks. Overall,

males reported only a slightly higher prevalence of injury in the previous four weeks (19%) compared to females (18%) (Australian Bureau of Statistics).

These general features of injury events in the community are to some extent mirrored in emergency department visits. In 2010, 45% of all New Plymouth District emergency department visits for injury were by children and young people aged 0–24 years and just 16% were by people aged 60 or more. More injury visits were by males (58%) than females (42%).

Looking at age-specific risks, the group in the district with the highest rate of emergency department attendance for injury was males aged 20–24 (24,493 visits per 100,000 population per annum). Next were males aged 15–19 (22,351 visits per 100,000 population). Amongst females those aged 80+ had the highest rate (14,273 visits per 100,000 population) followed by 15–19 year olds (13,347 visits per 100,000 population).

Similarly, looking at injury hospitalisations, in all age groups except the 70–79 and 80+ age groups, males have a higher risk of hospitalisation than females. The highest risk group for males is the 80+ age group (8,355 injury hospitalisations per 100,000) followed by the 20–29 age group (3,408 injury hospitalisations per 100,000). The highest risk groups for females are the older age groups. In particular, women aged 80+ have a one in 10 chance of being hospitalised in any given year for injury (10,291 injury hospitalisations per 100,000).

For children aged 0–9, falls are by far the leading cause of injury hospitalisations (42% of male and 49% of female injury hospitalisations).

Falls were also one of the three leading unintentional causes of injury hospitalisations in the 10–19 age group, along with transport accidents and exposure to inanimate mechanical forces (e.g. machinery or home appliances). Self-harm was the second most frequent reason for hospitalisation of females aged 10–19.

For males aged 20–29, exposure to inanimate mechanical forces, falls, transport accidents and assault are the four main causes of injury hospitalisation; for females in this age group it is falls, transport accidents, intentional self-harm, and exposure to inanimate mechanical forces, in that order.

Exposure to inanimate mechanical forces, falls, and transport accidents also dominate injury hospitalisations in the 30–39, 40–49 and 50–59 age groups, although for women in these age groups intentional self-harm is either the leading cause or one of the leading causes of hospitalisation.

In the older age groups, 60–69, 70–79 and 80+, falls begin to again become the dominant reason for injury hospitalisation, especially for women, with 51% of hospitalisations for females aged 60–69, 75% of hospitalisations for females aged 70–79 and 85% of hospitalisations for females aged 80+ caused by falls.

Injury trends over time for different age groups

As indicated earlier, New Plymouth District's all-age injury hospitalisation rates were lower than New Zealand's in every year from 1999 to 2010 (except 2009). This is after a period, from 1989 to 1998, when New Plymouth's rates were consistently higher than New Zealand's. In this regard it is interesting to note the following trends in age specific injury hospitalisation rates:

- in the 0–9 age group, New Plymouth District injury hospitalisation rates were very similar to New Zealand's throughout the period 1993 to 2003, but from 2004 to 2010 (with 2009 excepted) New Plymouth's rates dropped and were substantially lower than New Zealand's
- in the 10–19 age group, New Plymouth District injury hospitalisation rates were higher than, or similar to New Zealand's from 1989 to 2000, but from 2001 to 2004 New Plymouth's rates dropped well below New Zealand's. From 2005 to 2010 New Plymouth's rates rose again, though in every year except 2009 they remained lower than New Zealand's.

Similar patterns as those just described are evident in all other age groups. In particular, since 2000, compared to New Zealand as a whole, New Plymouth has had consistently lower injury hospitalisation rates in the 60–69, 70–79 and 80+ age groups (see figures 4.14, 4.15 and 4.16 in chapter 4) (see chapter 4 for details).

Injury prevention and safety priorities in New Plymouth District

As should be evident by now, the concept of injury encompasses a wide array of human experiences and behaviours. Based on World Health Organization definitions alone, it entails everything from the minor bruise received by walking into a kitchen cupboard to the multiple catastrophic injuries received by stepping on a landmine. It includes the myriad potential physical consequences of a host of common and not so common behaviours such as falling over, getting tangled up in machinery, getting cut by a sharp knife, riding a bicycle into a lamppost, staying out all night in the snow or living too close to a damaged nuclear power plant.

Other perspectives also include psychological or other types of harm in their definitions of injury and safety. This may include verbal abuse, theft of property, internet safety and so on.

From a prevention and safety perspective, given that resources are limited, this raises the important question: 'out of the wide range of types of injuries and safety issues that potentially can occur in a population, which ones should be the main focus of prevention programmes or safety initiatives?'

First steps to answer this question typically involve looking at existing injury data to get an idea of which types of injuries are most common in the community, including their severity and cost, and which population groups are most likely to experience them. This approach underlay development of the New Zealand Injury Prevention Strategy, for example, which identifies six types of injury as priority areas for action throughout the country. The injury types are: road crashes, suicide and

deliberate self-harm, falls, assault, workplace injuries, and drowning (Dyson 2003). Detailed background analysis for the strategy including looking at how many New Zealanders are injured in these and other ways, and estimating the treatment and rehabilitation, lost economic contribution and human costs of these injuries. On this basis, it was conservatively estimated that the total social and economic cost of all injuries in New Zealand is approximately NZ\$9.7 billion (at June 2008 prices). Just over half (53%) of this total cost is in the form of human costs; namely the losses associated with premature death from injury and the impacts of injury-caused disability on quality of life (Wren and Barrell 2010). Altogether, injuries in the six priority areas are estimated to account for 84% of the total cost of all injuries. The three most costly areas are road crashes, suicide and falls which together account for 63% of the total cost of all injuries.⁴⁶

As far as New Plymouth District is concerned, it is clear from the statistics presented in this chapter and elsewhere in the report that the district's main injury types are similar to New Zealand's in terms of their prevalence and severity; and that each of the six injury priorities identified by the New Zealand Injury Strategy have relevance for the district. However, as the authors of the background analysis for the New Zealand strategy acknowledge, compiling statistics and identifying broad priorities is really only a starting point. What is also required is some kind of process for identifying what kinds of realistic and appropriate (and hopefully effective) prevention and safety initiatives should or could be developed to address these (and perhaps other) priority areas and help reduce the total burden of injury experienced by the community.

For this needs assessment, to get a snapshot of the kinds of injury prevention and safety initiatives local people currently regard as important – and for which population groups – consultation interviews and focus groups were conducted with representatives from a selection of New Plymouth District organisations and an email survey was completed by members of the NPiS Trust group. The results of this process are fully described in chapters 11, 12 and 13. However, it is worthwhile summarising briefly here the main injury areas pinpointed by consultation participants and the suggestions they made for new prevention and safety initiatives to address them.

Three injury areas were highlighted in the consultation interviews that are also priorities for the NZ Injury Prevention Strategy; namely road safety (traffic injuries), workplace, and assaults (including family violence).

⁴⁶ In detail, road crashes are estimated to cost \$2.195 billion nationally and make up 23% of total injury costs. Corresponding figures for the remaining five priority areas are:

- suicide and self-harm: \$2.169 billion 22%
- falls: \$1.735 billion 18%
- workplace injuries: \$1.347 billion 14%
- assault \$379.6 million 4%
- drowning \$295.5 million 3%.

Of the three, road safety garnered the longest list of suggestions for new initiatives including using new technology (e.g. disabling devices for the cars of recidivist drink-drivers), legislation, enabling and supporting motorcyclists and cyclists to wear proper safety gear, developing better driver awareness and safety values, and developing safer environments for non-motor transport. Suggested new initiatives to promote workplace safety included more workplace safety programmes for small workplaces and sedentary computer workers. No suggestions were made for new initiatives to prevent assaults or family violence.

Consultation participants also identified four activities / sites associated with higher risks of injury; namely alcohol and drugs, sports / recreation, home, and rural / farms.

Alcohol, methamphetamine ('P') and cannabis were considered the three main drug substances linked to injury in the district. Suggestions for new initiatives to prevent misuse, including binge-drinking by young people, focused mainly on the need to change attitudes.

For sports / recreation places, suggested new initiatives included ensuring people wear the right protective gear (e.g. mouthguards, headgear) and making sport and recreation environments safer (e.g. pads around goal posts).

Suggested new initiatives for the home environment included falls programmes and an increase in injury prevention programmes targeting home injuries. Suggestions for the rural / farm setting included providing more rural injury prevention programmes and legislation requiring helmet wearing and the fitting of rollbars on all terrain vehicles (ATVs).

Finally, consultation participants highlighted four priority population groups; namely Māori, children / young people, middle-aged people, and older people.

Participants noted the need to strengthen Māori communities and build community networks and support for Māori in a healthy way. More specific suggestions included improving Housing NZ homes that have safety risks.

For children / young people, suggestions included educating primary school students about how to exercise and move to avoid injuries, and providing half-day courses for sports coaches to teach them how to avoid injuries when coaching children and young people.

No specific suggestions were made for safety initiatives targeting middle-aged people although it was observed there seem to be more middle-aged men injuring themselves on skateboards and surfboards.

New initiatives suggested for older people included schemes to reduce falls. This included improving access to people's homes, resuming and expanding existing falls prevention programmes (funding has been withdrawn for some), increasing the use of assistive technology (e.g. walking aids) and increasing the accessibility of gyms and programmes like Tai Chi so older people can try them out without having to commit to long-term use.

In terms of priority injury topics relevant to Māori, the Māori focus group listed water safety, road-related injuries, family violence, street violence (fighting), child neglect and abuse, child day-care accidents, older people, sports injuries and work-related injuries. Asked about injury prevention and safety initiatives currently going on in the district specifically for Māori, participants identified several projects or programmes, most of which were either winding down or on hold as a result of funding cuts or loss of key Māori community workers. They observed that no progress had been made to date on any of the three key recommendations of Poututangata report and probably, if anything, the situation had worsened recently with the loss of a very capable and well-respected community worker who had resigned to take up a position outside the region.

Current injury and safety issues in workplaces identified by the workplace focus group included: a lack of safety training; a lack of job fitness; a high level of diversity within the workforce; hazards relating to particular jobs; and a range of health and lifestyle issues from outside work (such as existing health conditions, drug and alcohol use, and fatigue).

Future injury and safety issues identified by the workplace focus group were: language and cultural barriers relating to new immigrant workers; people working from home and at other people's homes; allergies; unhealthy diets; sports injuries; and the ageing population.

The role of local injury prevention networks and coalitions – NPiS and the New Plymouth Safe Community

As will be clear from reading this report's opening chapters, a significant injury prevention initiative that already exists in New Plymouth District is the NPiS Trust and its associated networks. The Trust and its networks provide the infrastructure for the New Plymouth International Safe Community programme.

According to established principles of community development and intersectoral working for health, a key way to help counter the burden of injury in a community is to establish systems promoting greater collaboration and interchange between existing agencies and groups committed to or interested in reducing injury. Local agencies and groups are encouraged to recognise that they are engaged in a common struggle to reduce injuries, to exchange information and network with each other on injury and safety issues, and identify ways they can share resources and collaborate to develop and implement effective injury prevention and community safety projects and programmes.

This is argued to have a range of positive effects including overcoming the silo mentality that often operates within and across some agencies and groups. In principle, developing these local coalitions and collaborations offers scope to make more effective use of the often limited resources available for injury prevention and safety projects and programmes, reducing duplication, and providing 'more bang for the buck' as a result of the greater joined-up thinking and synergies created across and within different agencies and groups.

Since 2001, the NPiS group, now the NPiS Trust, has been the main local body, along with the New Plymouth District Council, championing the collaborative, intersectoral model for injury prevention espoused by the WHO / International Safe Communities movement. As discussed earlier, members of the Trust have played a key role in developing a range of initiatives intended to encourage a more unified and collegial approach to reducing the impact of injury and promoting a safety culture in the district. Now, more than a decade on, this third needs assessment attempts to systematically assess what impact the NPiS group has had, and continues to have, on the development of injury prevention and safety activities in the district. It is also timely to consider possible future directions for NPiS's work.

The main evidence used here to assess NPiS's past and present impact is the feedback from stakeholder group representatives, service providers, NPiS Trust members and other people consulted as part of the needs assessment. As noted earlier, consultation participants were asked a number of questions specifically designed to elicit comment on aspects of NPiS's work and the wider New Plymouth Safe Community. The results have already been reported in detail, especially in chapter 11. Here the key findings will be re-stated and examined in the context of other research on the impact of safe community initiatives and similar intersectoral injury prevention and safety coalitions.

Some readers may question the appropriateness of basing an assessment of the impact of NPiS and the Safe Community largely on feedback from representatives of agencies and groups already working with NPiS or operating under the New Plymouth Safe Community umbrella. Won't these people have a vested interest in presenting NPiS and the Safe Community initiative in the best possible light? How 'objective' is the feedback from these people given that many of them have worked in conjunction with NPiS on projects and programmes over the years? Wouldn't they therefore more likely to regard NPiS as positive or useful compared to other people in the community?

In defence of the decision to focus the consultation on this group, it should be emphasised that the consultation had to achieve a delicate balance. It needed to include people who were familiar enough with the NPiS and Safe Community initiatives to be able to offer informed comment about their activities and impact. But it could not cast its net too widely and include people who had very little contact with, or knowledge of NPiS or the Safe Community, since this would be a drain on the limited time and resources available for the consultation.

In the end it was recognised that, in keeping with research methodologies used in other evaluations of community initiatives elsewhere in New Zealand and worldwide, the soundest approach would be to aim to accurately gather well-considered feedback from people with some experience of the NPiS and Safe Community initiatives, but to include plenty of opportunities, and even encouragement, for these people to identify aspects of the initiatives that they disliked or disagreed with.

Including several people from local health treatment agencies in the consultation mix who had not worked directly with NPiS or under the Safe Community umbrella also was a deliberate attempt to broaden the consultation to include feedback from people who may not necessarily be committed to the injury prevention model espoused by NPiS or other related groups.

Looking through the consultation findings reported in previous chapters suggests this element of the needs assessment was successful enough in eliciting some fairly honest, no-holds barred feedback about NPiS and the Safe Community initiatives. Reassuringly there was a degree of consistency and overlap in the range of comments and suggestions made, whether positive and supportive, or highlighting areas of perceived difficulty and places where there was scope for improvement.

Awareness and impact of NPiS and the New Plymouth Safe Community

As described earlier in this report, and as would be plain to anyone who has read New Plymouth District's substantial International Safe Community reaccreditation application document (New Plymouth Injury Safe 2010), in recent years literally dozens of different injury prevention and safety projects or programmes have been running in the district involving some degree of joint-working between two or more local agencies or groups.

Those that could be regarded as generally more 'top-of mind' for the consultation participants are listed in chapter 11, although it should be emphasised that these are by no means a complete inventory of all the district's existing projects or programmes. As might be expected, the NPiS Trust and wider NPiS network is one initiative commonly singled out. However, several others are also listed. These cover a range of injury or safety topics and/or priority population groups including children and young people, older people, Māori children and older people, workplace safety, road safety, alcohol, self-harm and suicide, and family violence.

When asked for their views about the effectiveness of the local projects or programmes they had listed, consultation participants referred to a range of 'effectiveness' criteria they used to assess if a project or programme was working. For the most part these criteria tended to centre around some kind of assessment of how well the project or programme was engaging its key target audience or priority population groups, judged for example in terms of the number and kinds of people turning up to events or accessed by project staff in their homes or workplaces, and so on. In some cases informal or formal feedback was gathered from project participants to gauge how appropriate or useful they thought a project had been for them, as well as perhaps test what positive changes to people's knowledge, attitudes or behaviours the project had generated.

Some consultation participants also indicated they determined the potential or actual effectiveness of a project or programme according to the degree of logic and coherence apparent in its planning and day-to-day operation. If the project or programme had been developed on sound principles with a practical, evidence-based understanding of the problem at hand and how it could be realistically addressed, and if the project or programme had in turn been executed well, then there could be a reasonable degree of confidence that the project or programme had been effective. Other consultation participants indicated that they assessed the impact of programmes or projects mainly on the basis of changes in downstream measures such as use of emergency or police services.

Consultation participants' explicit or implicit references to these different criteria suggests that New Plymouth district agencies and organisations running injury prevention and safety programmes and projects have a good awareness of evaluation principles and a concern with showing evidence of effectiveness for the work they do. Although it is beyond the scope of the present needs assessment to review all the evaluation data collected and reports compiled on individual injury prevention projects and programme operating throughout New Plymouth District in recent years, a selection of evaluation reports on projects and programmes that NPiS has helped initiate, deliver, fund or in other ways support has been briefly examined for this report (see chapter 1).

As well as detailing how individual injury prevention projects and programmes are designed and delivered, these reports have been useful for pinpointing the array of criteria used to assess the effectiveness of local programmes and projects. In the main these criteria tend to focus on measures of effectiveness orientated to levels of uptake or participation by target audiences or priority groups, to levels of satisfaction with or approval of the project or programme by those participating in it, and to measures of change in the attitudes, beliefs or behaviours of project or programme participants, whether self-reported or according to more objective measures such as third-party observations of seat-belt use or the like. Few evaluations of local initiatives attempt to make any direct links between the successful delivery of a specific project or programme and changes in wider patterns of injury prevalence or injury-related service utilisation in the district, which seems to be entirely appropriate given the considerable analytic and methodological challenges associated with identifying such links (as will be discussed in more detail below).

Some consultation participants voiced uncertainties about the effectiveness of certain projects or programmes they had knowledge of - or indeed of injury prevention and safety promotion more generally - commenting for example that they seemed to be slow to have an effect, or only 'preaching to the converted' and not reaching perhaps the groups who needed them most. One or two referred to the inevitability of injury and the impossibility of removing all hazards or risks, implying that in most situations and contexts prevention efforts could only be marginally successful at best.

Overall, though, most consultation participants were more inclined to point to examples of what they considered successful and effective local programmes and projects. For instance, they singled out in the alcohol area initiatives such as New Plymouth District Council's Alcohol Strategy and the ThinkSmart sports club programme; from the workplace area - initiatives such as the Be Safe Taranaki (BeST) training centre and the Trade Apprentices Challenge; for children and their families - initiatives such as the child falls prevention programme and wrap-around services for the victims and perpetrators of family violence; in the area of crime prevention - initiatives such as the 'mellow yellow' city patrols and creation of an alcohol reduction officer position; in the area of suicide prevention - the distribution of the 'Turn the Page' resource; for older people - initiatives like the Tai Chi falls prevention programme, and in the area of road safety - initiatives like fatigue stops, video monitoring of intersection red-light runners, and the setting up of a boy racer skid track. There are of course likely to be many other current local programmes and projects that people would rate as successful and effective according to their own particular approaches to defining and assessing effectiveness.

Moving now to consider the position of NPiS and the New Plymouth Safe Community in the context of these and other local injury prevention and safety programme and projects, it is important here to remind readers that the Safe Community is an over-arching, rather abstract concept referring to the totality of local, collaborative injury prevention and safety projects and programmes operating in the New Plymouth District, and the nature of the relations between the various agencies and organisations running these projects and programmes. Essentially the Safe Community concept, based on World Health Organization guidelines and principles, is intended to help promote a greater awareness of a shared, community-wide focus on injury prevention and safety and encourage local agencies and organisations to work more closely with one another to achieve common goals related to agreed priority injuries and population groups. As noted earlier, New Plymouth became an accredited WHO Safe Community in 2005 and was reaccredited in 2010.

The New Plymouth injury Safe (NPiS) group, more latterly known as the NPiS Trust, along with NPDC, sit at the centre of the district's efforts to promote and make real the principles and goals of the Safe Community concept. In essence, NPiS is intended to be the district's core catalyst or engine-room for building and maintaining linkages and coalitions between disparate agencies and groups as envisaged in the WHO model. This includes compiling local data on injury and safety issues, building consensus on agreed priority areas for action, and encouraging greater collaboration and interchange between local agencies delivering projects and programmes addressing these priority areas.

The awareness of New Plymouth District's status as an International Safe Community was high amongst the consultation participants who were interviewed, with just one of the general / health interviewees not having heard of it. When asked what they considered to be the roles or functions of the Safe Community, consultation participants often referred to functions that were more clearly NPiS's rather than the broader Safe Community's (e.g. assisting in meeting International Safe Community criteria). It was less well known by people not closely linked to NPiS, e.g. the workplace focus group participants – with only one out of seven participants being aware of it. Three of the five Māori focus group participants had heard of it.

This melding of perceived roles and functions is probably understandable given the close inter-relationship between the two entities. Interestingly, at least one of the general / health consultees commented that a role of the Safe Community was to 'move from injury to broader safety issues'. This foreshadowed comments later in the consultation indicating debate about the range of hazards and safety risks to be included under the Community Safety Strategy.

Overall, when asked if the Safe Community / NPiS was making a positive difference, 25 out of the 32 consultation participants said that they thought it was. Six indicating they didn't know or were unsure. One consultee was unaware of the Safe Community and so was not asked the question.

When asked to identify ways the Safe Community / NPiS was making a positive difference, consultation participants referred to a range of activities and outcomes. Some of these can be considered to relate more to the impact of the broader Safe Community as a district-wide entity, such as providing a cohesive umbrella / community safety banner for related organisations and helping to establish a community safety culture in the district or 'creating a focus'. Others more clearly centred on the work done by the NPiS group and included: promoting networks and

partnerships across and between organisations; providing education, information and publicity in the form of newsletters, websites, seminars, newspaper articles and more; leading the Safe Community accreditation and re-accreditation process and ensuring WHO criteria are met; identifying gaps and priorities for evidence-based action; collecting statistics and leading the commissioning of the 5-yearly needs assessments; supporting partners to get funding and acting as a fundholder for them; and initiating new groups and programmes. One consultee stated that the Safe Community / NPiS had reduced injury 'in some areas'.

More general remarks praised NPiS for being 'very professional' and the 'brilliant job' they were doing. The role the programme manager had played was particularly mentioned. Some stressed how important it was that NPiS continues its work.

A small handful of consultees from the general / health interview group were more ambivalent or unsure about how effective the Safe Community / NPiS had been. They suggested some important population groups or segments were still not getting the message and wondered if injury and safety outcomes were improving much, if at all. The workplace focus group did not feel they knew enough about NPiS / the Safe Community to comment on how effective they were.

Impact on injury rates

It is appropriate at this point to briefly consider the question of the Safe Community's (and by implication NPiS's) impact on population-level injury outcomes, as it is clear a few consultees considered this to be the main or even the only criteria for effectiveness that really counted. Often it is the agencies (such as ACC) providing significant financial support for a safe community initiative which make the strongest appeals for evidence showing the initiative has had a positive impact on community-wide injury rates; which is understandable given that these agencies themselves are often being judged on the basis of high-level outcomes-related performance targets. Unfortunately, as much of the research on safe community initiatives indicates, evaluating the effectiveness of an initiative purely on the basis of trends in injury rates is not always appropriate or practical (UMR Research 2009).

One major potential obstacle is the extent and reliability of the injury surveillance systems available to monitor the incidence of injury and injury trends. As discussed earlier, very little routine data is available publicly for much of what might be called the New Plymouth District's 'injury mountain'. This especially includes the many tens of thousands of injury events that occur in the community every year that do not result in contact with a health professional, as well as the many thousands that involve contact with a general practitioner, private after-hours medical clinic or other community-based primary health care providers. The only routinely collected data is for emergency department visits, inpatient hospitalisations and deaths – the small part at the very top of the total injury mountain (though of course a very important part in many respects).

The potential problems this raises for determining the effectiveness of community-based injury prevention programmes and projects can be illustrated by using the example of falls. Findings from the Australian Health Survey on the all-age prevalence of falls, translated to the New Plymouth

District population, suggests that there may be somewhere in the vicinity of around 33-34,000 injury events per year in the district involving a fall of a metre or less (Australian Bureau of Statistics 2006). Yet, on average in recent years in the district, as reported in chapter 4, only 677 of these fall injury events, about 2%, result in inpatient hospital treatment.

Imagine there was an all-age falls prevention campaign running in the district aiming to encourage everyone to take steps to reduce the risk of themselves and other people falling over and getting injured. Imagine, too, that over a 12 month period this campaign was successful in preventing approximately 1,700 people from falling and getting injured. This 5% reduction in the community-wide incidence of fall injuries is arguably a useful contribution to reducing the sum total of fall-related distress and disability in the community, including health system costs.

However, because there are no reliable injury surveillance systems in place to accurately trace the incidence of fall injury throughout the community, the full impact of the campaign cannot be measured and acknowledged. Instead, measurement can only centre on the hospitalisation data. This may show a reduction of around 30 or so inpatient hospitalisations compared to the previous year - about one less fall hospitalisation every 12 days or so – however, because of the relatively small numbers involved this may or may not be a statistically-significant difference.⁴⁷

Readers may quibble with the assumptions and rough estimates used in this hypothetical example, but it does serve to illustrate the extent to which routine statistics are unavailable for many of the areas in the community where injury prevention projects and programmes are likely to have a positive impact.

Looking at the routine datasets that are collected, by international standards New Zealand is fortunate in having a comparatively robust injury hospitalisation and injury death recording system. In particular, it is the hospitalisation data which provides the best opportunity to trace potential changes in injury patterns over time in New Plymouth District, largely because of the greater numbers involved for the different injury cause groups and population age groups of interest. However, as many local injury researchers observe, hospitalisation data is not without its pitfalls and problems, especially when used as a basis for evaluating the impact of programmes or policies. There is a tendency to assume that hospitalisation data captures a clear snapshot of the incidence of different types of injury in a community, when what it is really showing is the special subset of injury types selected for treatment in inpatient hospital settings. Thus hospitalisation rates can be influenced by changing hospital admission policies and thresholds, people's ability to access services, the availability of new technologies and a variety of other service-delivery factors that have little connection to the actual incidence of injury in the community.

These issues have led some researchers to conclude that it is inappropriate to judge the effectiveness of safe community initiatives, including those in New Zealand, according to trends in

⁴⁷ As previous injury prevention studies have noted: 'It has been suggested that researchers and practitioners tend to expect too much from community-based programmes and that they fail to realise that widespread gains in public health often appear small' (Nilsen and Yorkston 2007: 248).

hospitalisation rates, especially if no adjustments are made to the data to filter out the relatively less serious injury hospitalisations which arguably tend to be much more subject to the effects of the above-mentioned service delivery factors (Langley and Simpson 2009, Nilsen 2005). The researchers suggest other criteria are more appropriate for assessing the impact of safe communities, such as surveillance data relating to the performance of recognised safety behaviours or practices such as cycle helmet use or improvements in playground equipment (Langley and Simpson 2009).⁴⁸ Some recent safe community evaluations have concentrated on assessing just one or two specific measures of effectiveness, such as use of child restraints in motor vehicles (e.g. Istre et al. 2011).⁴⁹

In much the same vein, overseas researchers point to the need to develop a more sophisticated and nuanced approach to assessing the impact and effectiveness of safe community initiatives; one that is not simply focused on whether or not hospital or other treatment rates for injury decrease (Doll et al. 2003, Hodge 2002, MacKay and Vincenten 2009, Nilsen 2005, Nilsen and Yorkston 2007, Ozanne-Smith et al 2002). They argue evaluations should use a combination of qualitative and quantitative research methods and, in keeping with the holistic principles of the Safe Community model, look to a range of outcomes as possible indicators of a successful safe community initiative.⁵⁰

Examples include the development of new policies or local laws or changes in behavioural norms and expectations in all or parts of a local community. Other suggested outcomes to be explored relate to the question: 'Was there, at least, evidence that programmes were easier to implement or more successfully conducted because of infrastructure attributable to the Safe Community?' (Johnston 2011: 1).

Some recent studies have aimed to identify key success factors and conditions that increase the chances of safe community initiatives making a positive impact; e.g. Nilsen (2004, 2005, 2007) and Nilsen et al (2005, 2006), Nilsen and Yorkston (2007), Nilsen, Bourne and Coggan (2007), Nilsen, Ekman, et al (2007), Nordqvist et al (2009), Roen et al (2006). Many of these studies note the complexity of the disparate contextual and programme-specific factors that inter-relate to produce a well-run and effective community-based initiative.

⁴⁸ For example, multiple studies demonstrate that community-wide projects to improve cycle helmet wearing by children can be very effective, and that it is comparatively easy from a research perspective to measure changes in rates of cycle helmet use by way of roadside observation surveys and the like (Spinks et al 2005). Much the same can be said for community-wide projects to increase the use of child-restraints in vehicles (Turner et al 2005).

⁴⁹ While road-safety related data like this has been reported in the current needs assessment (chapter 7), it is for Taranaki as a whole, not New Plymouth District.

⁵⁰ As Nilsen observes: 'An overall bias towards the positivist paradigm has been identified as a problem by many health and safety researchers, who have argued that research on community-based programs needs to move beyond a black box approach to program evaluation and toward a social science model, which acknowledges the importance of finding out how and why a program works by combining quantitative and qualitative data' (Nilsen 2007: 503).

The current needs assessment has used qualitative as well as quantitative research methods. However, a really thorough evaluation and impact assessment would require a great deal more time and resources than were available to the present project, and yet would still not necessarily guarantee definitive answers about whether or not NPIS / the Safe Community itself is 'causing' an improvement in local injury and safety outcomes.

Encouraging trends in New Plymouth injury rates

Having noted these reservations about the appropriateness of relying solely on hospitalisation data to assess the impact of New Plymouth Safe Community and NPIS, it is still important to recognise the encouraging trends evident in many of the time-series injury hospitalisation charts in chapter 4.

In particular, as noted earlier in this discussion, New Plymouth District's comparatively low all-age injury hospitalisation rates from 1999 through to 2010 (apart from 2009), which is essentially the period in which the NPIS group has been functioning, is suggestive that one or more positive things have been happening in the district to reduce injuries leading to inpatient hospital treatment. There may have been some sort of local hospital-wide service delivery change that influenced these rates (e.g. new technology or procedures enabling more injury cases to be treated in the emergency department and then sent home rather than hospitalised) although this is mere conjecture at this stage, unsupported by evidence. It is equally possible to conjecture that it is a result of concerted efforts by different agencies and groups in the district, including NPIS, to reduce the incidence and severity of injury in the population through injury prevention initiatives.⁵¹

Similarly, the data indicating New Plymouth District's fall injury hospitalisation rates trending notably lower than New Zealand's, especially between 2004 and 2008, is also encouraging and suggestive of a positive impact, assuming local changes in hospital service delivery are not a major determinant. In particular, the fact that New Plymouth's rates for children aged 0–9 dropped so much lower than New Zealand's in the mid 2000s, and that New Plymouth's rates in the 70–79 and 80+ age groups were consistently lower than New Zealand's, is also suggestive that the child and older person focused falls prevention projects and programmes running in New Plymouth over this time may be helping to making a difference.⁵²

⁵¹ Internationally, other Safe Communities in Sweden (e.g. Lidköping, Katrineholm, Falköping, Tidaholm, Nacka, Motala), Australia (Illawarra) and New Zealand (Waitakere) report reductions in either all-age or age-specific (e.g. children aged 0–14) hospital treatment rates coinciding with implementation of injury countermeasures (Lindqvist et al 2002, Nilsen, Ekman et al 2007, Spinks et al 2004). Trend analysis, where historical data from the community is traced before and after the implementation of safe community interventions, is considered a legitimate method for identifying possible intervention effects. Stronger study designs involve comparing data from control communities; that is cities or districts similar to the Safe Community. For the current needs assessment, time series data for New Plymouth District has been compared with New Zealand (i.e. the national average). Readers requiring a comprehensive systematic review of injury outcomes data for 21 WHO designated Safe Communities in Austria, Sweden, Norway, Australia and New Zealand should see Spinks et al (2009).

⁵² A 2005 review of studies of community-based interventions to prevent falls among children found only one WHO safe community, Motala, in Sweden, had published evaluation data suggesting the safe community initiative

The same can be said for New Plymouth District's lower transport accident injury hospitalisation rates over this time compared with New Zealand.

Safe Community website and Community Update newsletter

Returning now to look at other impacts of the work of the NPiS group and the wider Safe Community that can be traced with more reliability, this section briefly considers the consultation feedback on the New Plymouth Safe Community website and the Community Update newsletter.

Intriguingly a third (8) of the 24 consultation interviewees asked about the Safe Community website either hadn't heard of it or had heard of it but never visited it. Just 3 of the 24 people said they visited the website several times in the past 12 months, while a further 8 said they had visited it 'once or twice'. This suggests there is perhaps scope to publicise and promote greater use of the website among core members of the Safe Community network.

People who had visited the website appreciated how it provided a way to find out what other agencies were doing in their area of interest and check for upcoming events. They also liked the functionality allowing agencies and groups to directly input their own information, news and advertisements. In the main people liked most features of the website and were content with it as it is.

A few made suggestions for improving the site, such as making it perhaps a bit less complicated or 'busy' and easier for less-experienced computer users to navigate round. One person thought the site needed more visual appeal. The most frequent suggestion was that a person be employed to regularly update and review the website content and encourage others to do the same.

The monthly NPiS Community Update newsletter was read either in whole or part every month by 17 of the 24 consultation interviewees, which seems a pretty good coverage. In contrast to the website, the newsletter is a 'push' form of information provision in the sense that it is emailed out to people rather than relying on them electing to go to a website. Three people had never seen or received the newsletter, including two who might have expected to be on the mailing list. Judging by what consultation participants indicate, it seems likely a lot of people in agencies across the district receive the newsletter as a result of it being forwarded on through various mailing lists.

According to consultation participants, appealing features of the newsletter included its brevity, simplicity and ease of understanding. Readers liked to be kept up to date and several consultation participants commented that they found the newsletter informative and interesting. One or two

contributed to a reduction in child falls. The Motala evaluation traced pre- and post-intervention trends in fall-related injuries in children aged 0–15 treated in health care units and the local hospital (McClure et al 2005: 468). Other systematic reviews of the effectiveness of evaluated community-based interventions have concluded that initiatives targeting fall-related injuries in older people, pedestrian injuries in children and bicycle helmet use among children have the most convincing evidence of effectiveness (Nilsen and Yorkston 2007).

people wondered about the relevance of the newsletter for their work and the cost-effectiveness of producing it, although these tended to be people working outside core NPiS injury prevention networks. Suggested improvements included design and layout changes to make the newsletter's text slightly less cramped and compressed. Some wanted the file size of the electronic version to be reduced so it would download faster on dial-up internet connections. One person suggested a corner of the newsletter be devoted to Māori news and issues.

Overall, there was more awareness and use of the newsletter than the website. This may be partly because the newsletter has been distributed for much longer than the website has been operating.

Past and future function and operation of NPiS

A large part of the community consultation involved inviting participants to comment on past, present and future aspects of the operation and impact of NPiS and the wider Safe Community. This included asking whether people had noticed any changes in the running or delivery of NPiS and the Safe Community in recent years, what they thought of these changes, and what suggestions they had for enhancing the operation or impact of NPiS and / or the Safe Community in future. In addition, in the email questionnaires completed by members of the NPiS Trust group a set of questions also sought comment specifically on what members considered to be the benefits and costs of being a representative on the group and their views about aspects of the current operation and structure of the group. Viewed as a whole, the feedback offered by consultation participants in response to these questions helps crystallise and bring to the fore some of the key issues the NPiS Trust and its partner organisations currently appear to be grappling with regarding the future operation and direction of NPiS and the wider Safe Community.

Looking back at what the NPiS group and the Safe Community has done in recent years, consultation participants who had had anything to do with running injury prevention and safety promotion projects or programmes in the district almost invariably commended NPiS for its work and achievements. Overwhelmingly the comments were positive and supportive. This fits the considerable body of written material that NPiS and its partner organisations and networks have produced since 2001 charting their activities and work. This includes multiple strategy and planning documents, evaluation reports on specific prevention and safety projects and programmes, accreditation applications, newsletters, publicity flyers, meeting minutes and much more. Reviewed chronologically, these documents point to a steadily growing momentum in the work of the NPiS group and its wider Safe Community partners, culminating in formal accreditation as a WHO Safe Community in 2006 and boosted further in 2007 by appointment of a very capable full-time programme manager. In the two or three years after this, the influence and impact of NPiS as a catalyst for creating more joined-up thinking between local agencies and organisations and for developing new prevention and safety promotion activities in the district appears to have grown even further, highlighted by New Plymouth's successful re-accreditation application and formal re-designation as an International Safe Community in September 2010 and launch of NPiS's new website a month later in October.

Judging by feedback from consultation participants, including NPiS Trust members, in conjunction with remarks in reports, meeting minutes and other NPiS documents, it seems a range of factors

have contrived in the last 12 months or so to take some wind out of the sails of NPiS and the wider Safe Community initiative. Not the least of these has been the downstream impacts of the ongoing global economic downturn and the consequent pressures on central government funding for health promotion and safety programmes generally. This has led to reviews and reassessments of funding priorities, the consequences of which have started filtering down to local agencies. In 2010 one of NPiS core funding partners (ACC) indicated that it was no longer in a position to help part-fund the NPiS programme manager position. With sustainable funding for the position in doubt, the programme manager resigned in October 2010. NPiS has not employed any staff since then.

According to several consultation participants, the resignation of the programme manager was a significant loss to the district, particularly in terms of having someone working actively on the ground on a day-to-day basis promoting the NPiS and wider Safe Community message, growing and preserving local networks, identifying gaps and unmet needs, and initiating and running new local collaborative safety projects and programmes. Members of the NPiS Trust also noted how much of a contribution the programme manager had made to the preparation for and smooth running of monthly Trust meetings.

Since the resignation of the programme manager, NPiS Trust group members appear to have tried to keep as many as possible of NPiS's existing roles and functions in place. The work for this is being done by Trust members either as part of their current job or in their own time. Funding originally intended to help part-fund a programme manager position continues to be provided by Taranaki District Health Board. New Plymouth District Council also continues to provide funding for safe community projects through its Community Grants scheme (this excludes support for the programme manager / co-ordinator position). Financial assistance to help support programmes and projects is also obtained from ACC and other local agencies linked to the Trust or wider NPiS networks. In general, though, despite these positive efforts by some highly committed and capable Trust members, and the continuing financial and in-kind support provided by partner agencies, there are hints that NPiS has lost some momentum over the previous 12 months or so.

This situation appears not to be unique to New Plymouth. Consultation as part of a recent evaluation of the New Zealand Injury Prevention Strategy found concerns in other communities about lack of sustainable long-term funding for injury prevention initiatives. Funding pressures were exacerbated by different agencies having different funding cycles and reporting requirements, making programme planning difficult and making it hard to attract and retain skilled and experienced staff (Litmus Ltd 2009, NZIPS Secretariat 2010).

It also found a lack of consistency in the types of funding models evolved to support safe community initiatives.

In one city, a programme co-ordinator position had been jointly funded by the city council, Ministry of Health and ACC but the latter withdrew its support in 2009–10. In another city, ACC and the city council each provide solid funding contributions, backed up project and programme funding from other partners including a safer city trust group, the Police, Housing New Zealand, and the regional public health service. In a third city, all funding for the initiative - some \$300,000 in total - came

from the Ministry of Health and covered co-ordinator salaries as well as the running of prevention programmes (NZIPS Secretariat 2010).

This patchwork of funding models and inconsistent funding streams may partly stem from the fact that, at a national level, responsibility for injury prevention is shared across a number of central government agencies. While for some of these agencies, such as ACC, injury prevention is supposed to be its core business, for others it is not necessarily one of their top priorities. Even for ACC, its injury prevention priority may be competing with its attempts to reduce levies (Langley 2010).

In December 2011, ACC announced a new funding formula for New Zealand Safe Communities. This enables NPiS to apply for up to \$32,000 annually in each of the next two years for work relating to ACC's injury prevention priorities, including project co-ordination work. This means NPiS, if it is successful in securing some of this funding, may be able to employ a new programme manager (see next section).

Enhancing NPiS future impact

As might be expected given the comments just noted, a very common suggestion by consultation participants was that NPiS should employ a new programme manager; or more specifically that sufficient funding should be obtained to make it viable to employ a new programme manager, and for this person to be able to have confidence that their position would be reasonably secure. Presumably there would be an even greater need for and benefit from having a programme manager if NPiS was to expand and re-focus its work on broader whole-of-community safety issues.

Some consultation participants identified topics that needed extra attention or greater development within the existing boundaries of NPiS and the Safe Community. These included Maori safety issues, intentional self-harm, family violence, workplace safety and injury prevention at home safety.

More broadly, some contrasting ideas were expressed about the degree to which in future the NPiS group itself should take responsibility for running specific 'on the ground' injury prevention projects or programmes in the community. Presumably a key example of this would be during the time the programme manager was employed, when she was often closely involved with the development and delivery of various community safety projects. Some consultation participants felt the NPiS group should be doing more of this 'practical' type of prevention work rather than engaging in too much esoteric strategic planning. Others had the opposite view and felt NPiS's future core role should be strategic planning and co-ordination across the entire local injury prevention and safety sector, but with no or minimum involvement in the direct delivery of projects and programmes. A related suggestion was that NPiS assumes more of an evaluation role for local programmes and projects, encouraging and supporting organisations to evaluate their activities and make changes in line with the findings.

One suggestion was for NPiS to formally extend its geographic boundaries of interest to include the whole of Taranaki. This was argued to be important for equity reasons, given that much of the

Taranaki region outside the New Plymouth District is rural, socio-economically disadvantaged and includes a high proportion of Māori. As indicated in chapter 1, there are already several examples of NPIS playing a central role in the development of Taranaki-wide strategies and other initiatives in areas such as falls, suicide prevention and injury prevention for Māori.

In response to questions about the future role of NPIS, members of the Trust group largely reiterated the importance of maintaining or enhancing existing roles and responsibilities. These included acting as the local co-ordinating body, establishing and strengthening networks, and raising awareness and motivating people to reduce injuries and increase safety.

More particularly, group members referred to activities such as research and analysis of the New Plymouth situation, disseminating information, developing and monitoring progress towards agreed strategies and priorities, supporting best practice and evidence-based community initiatives, and facilitating new initiatives to address gaps in existing injury prevention and safety programmes, and maintaining New Plymouth's International Safe Community accreditation.

Suggestions by members of the Trust group about ways the group could be better organised or operate in future included expanding the representation of the group to include people from local organisations promoting workplace safety, family violence prevention, road safety, community justice and civil defence. However, other Trust members were more cautious about the idea of expanding the group, arguing that the existing group had far-reaching networks that linked to every relevant local community organisation and group. More important was that the existing group members had the right mix of skills to undertake NPIS's core responsibilities and that the group was a manageable enough size for decisions to be made and acted on reasonably quickly.

All eight Trust members consulted observed that generally the monthly meetings of the Trust were useful and well-organised. A few suggested that in future some of the group's day-to-day business be handled more by email, to free up more time at monthly meetings for productive discussion. In this regard it was noted by some that it would be useful if emails were replied to a little more promptly in some instances. Another request was that group members come to meetings better prepared, having done the necessary background reading and thinking required. Not having a programme manager was considered to lie at the root of some of the recent issues relating to the running of the Trust group.

Some Trust group members noted uncertainty about the precise role they were expected perform. Was it primarily a governance role overseeing the administration of the Trust or was it more providing input to broader strategising and discussion about joint community safety initiatives? Some members noted it would be useful to provide a more comprehensive induction process for newcomers to the Trust group. This might include a written agreement outlining a member's expected roles and responsibilities.⁵³

⁵³ Following on from an organisational review of the Trust in September 2010, steps have been taken recently to develop an induction process for new members and a policy/procedure manual for guidance.

As might be expected, hardly any Trust group members thought the current processes for getting funding to support NPiS's work were fully effective. Some noted the difficult economic circumstances generally. Others reflected ruefully on the opportunities lost because of the Trust's diminished funding base and unsecure financial future. Three Trust members observed that in future the Trust would need to remain aware of and responsive to funders' expectations, including achieving outcomes. Also of note, there has been some debate in the Trust group about the ethics of approaching certain charitable organisations for funding support, such as charities deriving revenue from gambling.

Community Safety Strategy

Aside from loss of the programme manager, another contributing factor to NPiS's possibly slightly decreased dynamism over the past year or so appears to be some questioning by Trust members of NPiS's core tenets and future direction. The genesis for this seems to be NPiS's involvement, stretching back to 2009 or earlier, in the development of the initially District Council led draft New Plymouth Safe and Secure Strategy; now known as the draft New Plymouth District Community Safety Strategy (New Plymouth District Council / New Plymouth Injury Safe 2011). In its original published form, this draft strategy included a major emphasis on crime prevention and other issues more traditionally aligned with the justice and welfare sectors and until recent years addressed at the local level by the now defunct New Plymouth Safer Community Council.

More recently, NPiS has been asked by the New Plymouth District Council to lead the community consultation process for the latest version of the Community Safety Strategy. This has helped fuel considerable discussion among Trust group members about what is, or should be, NPiS's identity and role as a catalyst for promoting safe community concepts. It seems the new Community Safety Strategy is designed to be a genuinely all-embracing strategy covering all safety dimensions. This includes injury as well as more law-and-order orientated concepts of community safety. The latter includes threats not just to individuals' physical safety, but also threats to personal and public property, and the population's collective perception of how safe the community is to live in.

A third model – community development – also features in some of the ideas behind the Community Safety Strategy, in particular the inclusion of the healthy and secure homes programme element. The model is based on strengthening communities by improving their broad social and economic conditions so that a whole host of outcomes will improve (including injury and safety-related ones).

The dilemma for some long-standing members of the NPiS group is whether it is advisable for NPiS to fully throw its weight behind these new conceptions of community safety or hold on more or less to the established parameters and priorities worked out over the years as part of applying the WHO / International Safe Community model. This model historically has its origins in mainstream health sector concepts of injury that focus largely on hazards threatening people's physical safety, although purely psychological harms are also recognised where clear causes are evident.

Possible reservations about fully committing NPiS to a central role in the development and running of a wider, more broad-based community safety initiative may partly stem from concerns that existing priority areas might get neglected, or that traditionally loyal supporters and funders may begin to feel their areas of interest are not being represented or worked on as fully as before. There may also be concerns that a broader focus will inevitably require expanding the size of the NPiS Trust group, which could lead to additional strains and tensions arising from the need to prepare for and run bigger, more formal meetings and achieve consensus with a wider array of partners from diverse areas of the community.

It should be emphasised that the statistical chapters in this needs assessment are not intended to provide categorical answers to questions relating to what should or should not be the future priorities and boundaries of NPiS's work. As the safe community literature indicates, local statistics provide a starting point for debate about priorities and strategies but subsequently the process is usually one of discussion and negotiation between actively-involved community agencies, groups and networks. Final decisions tend to be based as much on political and value-driven judgements, and on what is agreed to be achievable (and fundable), as on safety and injury data per se. Fundamentally, the WHO / International Safe Community model stresses the importance of communities themselves defining their injury and safety priorities and going on from there. In conjunction with this, another layer of knowledge is required on what types of prevention and safety projects and programmes are likely to be practical and work in the community in question.

That said, there can be no question that historically NPiS and the wider New Plymouth Safe Community initiative has attached a high importance to local data as a spur for action and, as this needs assessment demonstrates, much of the most useful data comes from public hospital statistics. As the detailed analysis of national-level data completed as background for the New Zealand Injury Prevention Strategy shows, there remains a considerable injury burden still to be addressed in New Zealand centred largely round six main groups of injury: motor vehicle traffic crashes, suicide and deliberate self-harm, falls, assault, workplace injuries, and drowning. While some inroads may have been made nationally to reducing these, such as in the area of motor vehicle crashes, it is unlikely that the relative importance of these six injury categories will change anytime soon.

This is shown in the local New Plymouth data, too. Despite indications New Plymouth's injury hospitalisation rates for falls and traffic crashes may have declined relative to New Zealand's over the last decade, these injury types still remain two of the most important in terms of their downstream costs to the district as a whole, as represented by their dominance of local hospitalisation and mortality statistics. In this sense, there are potentially strong arguments NPiS could make for 'sticking to its knitting' and continuing to focus on its established priorities for injury prevention and safety promotion. There is always likely to be plenty left to do.

Priorities in other NZ Safe Communities

A review of the websites of other accredited safe community initiatives operating in cities, towns and districts in the lower half of the North Island indicate that there are precedents locally for adopting an expanded view of the boundaries of the safe community model. This includes giving

greater emphasis to law and order issues and related areas than perhaps arguably has been evident in the core work of NPiS and its partners in recent years.

A prime example is Safe City Wellington. Judging by the content of its Safe City Wellington document (Wellington City Council n.d.), this initiative has a very strong focus on crime reduction and reducing anti-social behaviour, especially in the inner city. One of the main stated goals of the initiative is to make people feel safer in downtown Wellington, especially at night. Linked to this is an emphasis on reducing alcohol-related misbehaviour and street crime. Reflecting this focus, in the document the Police are almost always the first agency listed whenever key agencies linked to the initiative are named. It seems, too, that injury prevention in the more traditional sense was a relatively late addition to the Wellington initiative, appearing to be peripheral to the initiative's main goals in the first few years the initiative was active.

In Safe City Wellington's December 2011 application for re-accreditation as a WHO / International Safe Community, the six leading topics covered in the document (i.e. those listed first) were: crime prevention, graffiti management, CCTV, city safety officers, neighbourhood support, and community patrols (Wellington City Council 2011). The remaining topics were: emergency management, earthquake prone buildings, falls prevention, youth development programmes, suicide prevention, family violence, road safety, workplace injury prevention, water safety, Wellington City Housing – Community Action Programme, Pacific peoples' safety, safety in the home, older people and urban planning.

Safe City Wellington's key partners are listed as Wellington City Council, Wellington City Police, Accident Compensation Corporation (ACC), and Capital & Coast District Health Board (CCDHB). The initiative's core intersectoral co-ordinating group is the Wellington Safe City Collaboration Group, which meets monthly. Funding sources for projects and programmes activities include the Council, Ministry of Justice, ACC and the Alcohol Advisory Council (ALAC). Outcome measures to be monitored to assess the impact of the initiative focus on: incidents of crime (especially family violence and public disorder and violence); community resident's perceptions of safety; emergency department and hospital injury data; ACC claims data; and road traffic crash statistics.

Most recently the Wellington City Council's website, on the webpage entitled 'Community Safety' has highlighted two initiatives: 1) the 2010/11 Safe in the City's 'Stick with your Mates' project aimed at increasing awareness of personal safety when out drinking and partying in the city, 2) the council operated closed circuit television surveillance system in the Te Aro area of central Wellington (Wellington City Council n.d). Cameras are monitored by the council's 'Walkwise' city safety officers who are in radio contact with the Police.

There is not space to discuss in detail relevant features of other lower North island Safe Community initiatives, but in brief:

- the three core focus areas for the Porirua City Safe Community initiative are crime prevention, road safety and injury prevention, as indicated by the city's 2008 re-accreditation document (Porirua City Council 2008)

- the Safe Hutt Valley Project covers Lower Hutt and Upper Hutt cities and was accredited as a WHO / International Safe Community in 2010. Its interagency group includes representation from the two Hutt city councils, the local DHB, Regional Public Health, ACC, Police, Awakairangi Maori Regional Board and Ministry of Justice. A Safe Hutt Valley strategy was developed with community input in 2011 and now consists of four main workstreams: injury prevention, crime and crash prevention, alcohol harm minimisation, and suicide prevention (Hutt City Council 2012).
- impetus for developing Whanganui's accredited Safe Community stemmed from the demise the city's crime prevention focused Safer Community Council. Priorities for the initiative (as at 2010) are road safety, family violence, safety and well-being (at home, sport, and work), alcohol and other drugs, emergency planning and justice (Safe Wanganui 2010).
- The Safe Wairarapa initiative covers Masterton, Carterton and South Wairarapa districts. The initiative arose out of local violence prevention campaigns started in the region in 2002. Currently the safe community's main 'work streams' are: violence prevention / intervention, fire safety, falls prevention, road safety, suicide prevention (mental health promotion) and alcohol and drugs (Safe Wairarapa 2010).
- Main funding partners of the Taupo District Safe Community are Taupo District Council, ACC, Lakes District Health Board and Police. The initiative has a fourfold emphasis on health, safety, crime and injury prevention. A coalition steering group meets monthly with representation from the above four agencies plus Fire Service, St John's Ambulance, Town Centre Taupo, Land Transport, and Water Safety NZ. Of the five main goals listed in the initiative's project plan, the third relates directly to crime prevention and includes the commitment to 'provide active support to locally led initiatives that make significant contributions to reducing the incidences and effect of crime' (Taupo District Safe Community 2010: 18).
- Initial impetus for development of Rotorua's WHO / International Safe Community, Treasure Rotorua, came from the Rotorua District Council, following the disbanding of the district's Safer Community Council in 2004. Guided by a steering group of representatives from organisations including the council, ACC, Police, Toi Te Ora Public Health, Iwi representatives and the Ministry of Social Development, the initiative has an over-arching priority of reducing alcohol-related harm. Linked to this are three 'highest priority' areas of concern: reducing crime and violence, road safety and injury prevention. Four 'over-represented' population groups are singled out for attention: youth, Māori, the elderly and visitors to the district (Rotorua District Council 2012).
- Napier's Safe Community initiative differs to some degree from the previous examples in that it takes a much broader safety focus, aiming to address safety, health and social wellbeing issues all under the one over-arching umbrella (Safe Communities Napier 2010). Facilitated, funded and led by the Napier City Council, the initiative's four main focus areas of community safety are housing, youth and community, crime prevention, and injury prevention. Awarded Safe Community accreditation in 2010, the initiative's

Safe Communities Napier Committee (SCNC) is relatively large and includes representatives from central and local government agencies (e.g. ACC, Police, Department of Internal Affairs, Hawke's Bay DHB, Housing NZ, Ministry of Social Development, NZ Fire Service, NZ Transport Agency (NZTA), RoadSafe Hawke's Bay) and non-government organisations (e.g. iwi representatives, primary health organisations, community worker organisations, disability trusts, Students Against Driving Drunk, and Sport Hawke's Bay).

Also perhaps pertinent to note is the statement of Strategic Intent of the Safe Communities Foundation New Zealand, the organisation responsible for guiding the development of safe communities in New Zealand. The statement indicates the foundation is concerned with community safety in the wider sense, including crime and anti-social behaviour, not just mainstream health sector notions of injury prevention. Objective 7 of the statement, for example, reads: 'Contribute to reductions in the New Zealand injury and crime burden' and objective 3 states: 'Facilitate access to regional and national data to identify groups at high risk of injury and crime' (Safe Communities Foundation New Zealand 2012).

Now it is obvious that each NZ safe community has its own unique colour and character depending on its origins and the safety areas its participants identify as important to work on. And it may well be that these other lower North Island initiatives give a comparatively high status to law and order issues and crime prevention at least partly because historically some of them have been formed out of the remnants of the now no longer operating Safer Community Councils. More broadly, too, there may be wider political and ideological forces at play in debates over community safety concepts and priorities. Political positions emphasising notions of small government and individual responsibility tend to give more attention to law and order issues. Positions emphasising the collective duty of citizens to look out for each other tend to be more prepared give priority to health and community development issues.

Feedback on draft New Plymouth District Community Safety Strategy

NPiS appears to be still to be in the process of deciding whether to fully commit to being the lead group responsible for facilitating a broader community safety initiative in the district. However, in the meantime it has agreed to take responsibility for gathering community feedback on the draft Community Safety Strategy. To assist with this work, chapters 11, 12 and 13 each include a section summarising the comments made by consultation participants about the draft Community Safety Strategy.

Overall it would be fair to say that the initial reactions of consultation interviewees to the content of the strategy were mixed. Perhaps half were at least reasonably happy, with the remainder expressing some ambivalence or reluctance to give the document their full blessing in its current form. It seems few were opposed to the idea of having a formal, written strategy (although a few wondered what was wrong with NPiS's current one, why have another one?), it was more a question of whether or not they agreed with the new strategy's current priorities and wording.

Looking at the content, there were on the one hand several people who remarked how they liked the strategy's clear and comparatively simply layout, and its relative ease of understanding. On the flipside there were others who considered the content to be 'wordy' and expressed at such a high level of abstraction and generality that it lacked scope for practical application. Others had reservations about what they saw as the strategy's unrealistic and 'utopian' goals – objectives that were too idealistic and impossible to achieve. Some people wanted to see more explicit statements of action in the strategy, even to the point of defining clear outcome measures that could be evaluated.

Another regular observation was that the strategy lacked a clear statement of responsiveness to Māori.

The latter point was restated in the special Māori focus group discussion. Members of the group queried the level of Māori input into the draft strategy to date and noted the absence of Māori concepts and Te Reo. They contended that alongside or within the strategy there was a need to develop a Māori-specific strategic plan focusing on issues affecting Māori in the district. This would stand apart from the 'across-the-board' issues identified in the safety strategy. In addition, they suggested, the Māori plan should be expanded to the entire Taranaki region, perhaps with different approaches for the north and south of the region depending on the issues addressed. One suggested option was that there should be a Māori action plan for each of the strategy's eight priority areas.⁵⁴

The ranking of priority topic areas by the needs assessment's general consultation participants saw alcohol given the top spot (see chapter 11). Interestingly, this fits with the conclusions of a consultation conducted as part of a review of the national-level NZ Injury Prevention Strategy. This found that, along with child injury, issues of alcohol-related injury cut across most, if not all, of the strategy's existing six priority areas (NZIPS Secretariat 2010). In short, it was a driver of injury on a number of fronts. As just one example, in the working age adult population there is a close relationship between acute alcohol use and the risk of fall injuries at home.

As for the idea of adding the topic of drugs alongside or beneath the alcohol topic, there was mixed support for this among New Plymouth District consultation participants. It was observed by a few that much illicit drug use was hard to prevent using current approaches. Too much attention to this issue might use up valuable resources better spent in other areas. On the other hand a larger

⁵⁴ Evaluation feedback on the national-level New Zealand Injury Prevention strategy also identified concern that Māori had 'limited visibility' in the strategy despite being a population at high risk of injury. This lack of visibility was characterised by low representation in governance groups, limited availability of injury data specific to Māori and a limited willingness by agencies to fund Māori models of injury prevention delivery (Litmus Ltd 2009, NZIPS Secretariat 2010). Solutions proposed included requiring lead agencies to address Māori specifically as a risk group in sub-strategies where appropriate. In addition, as a response, it was recommended that four cross-cutting 'focus areas' be added to the New Zealand strategy, sitting beneath the strategy's six priority injury areas. One of the four suggested focus areas was Māori. The other three were alcohol, community engagement and child injuries (for children aged 0–14).

number of interviewees and the two focus groups believed that, like alcohol, use of illicit drugs such as cannabis and 'P' is a major driver of injuries and other safety issues in the district.

The ranking of crime prevention in third equal spot beside injury prevention suggests there is reasonable support for this topic having a prominent place in the finalised strategy, notwithstanding the potential risks referred to before of NPiS straying too far outside of its established areas of focus.⁵⁵

As far as interviewees were concerned, perhaps the topics most vulnerable to exclusion from the strategy were emergency management and secure and healthy homes. Both these topics were sometimes observed to be on the margins of relevance as drivers of physical injury. Healthy Homes was seen as perhaps being more relevant for respiratory illnesses and the like; in other words ticking the 'disease' box more than the 'injury' box. Emergency management tended to be interpreted as referring to earthquakes, tsunami and volcanic eruptions; as one person put it, 'high consequence but low incidence'.

Workplace safety was ranked sixth out of the eight topics. This ranking may partly reflect the backgrounds and roles of the consultation interviewees, many of whom were working in areas not traditionally closely allied to workplace health and safety. As the evaluation of the New Zealand Injury Prevention Strategy observed, 'public-health-oriented community injury prevention practitioners and their workplace occupational health and safety colleagues tend to interact little on a more day-to-day level' (NZIPS Secretariat 2010).

This was one reason for holding a special workplace injury focus group discussion for the needs assessment, to ensure perspectives from a range of local workplace health and safety people were incorporated into the project. People in the group agreed it was appropriate and even 'imperative' for workplace safety to be included in the Community Safety Strategy, though some concerns were raised about the strategy's actual wording including use of the concept of 'zero harm' (see chapter 13 for details).

Judging from these and other comments by the group, if NPiS wants to strengthen the links between workplace safety culture and community safety initiatives in the district, a crucial first step may need to include some kind of low-key marketing or publicity specifically targeting workplace health and safety personnel to bring them up to speed with NPiS's vision, philosophy and goals. Although NPiS is already involved in some reasonably high-profile local workplace safety initiatives, this appears not to have translated through to a broader recognition by those involved in workplace safety of NPiS's special over-arching responsibilities, or a sense that workplace participation in the wider Safe Community programme has something valuable to offer the entire community.

⁵⁵ It is worth noting that analysis for the evaluation of the New Zealand Injury Prevention Strategy found that nationally rates of serious, non-fatal injury caused by assaults rose by 50% between 2003 and 2008. However, the analysis observed that some of these increases 'may reflect higher levels of reporting, as public awareness improves around the need to report violent acts, such as family violence and sexual violence' (NZIPS Secretariat 2010: 20).

Conclusion

This third New Plymouth District injury prevention and safety needs assessment has presented the latest available data on injury patterns and safety-related risk factors for the district. It has also indicated what people from local agencies and organisations regard as the most important injury and safety issues confronting the New Plymouth population and possible actions for positively addressing these issues in future. As well, feedback has been presented on the quality and impact of the work of NPiS and the wider New Plymouth Safe Community initiative.

When combined with the information from the district's two previous needs assessments, there is now available a detailed collection of local injury and safety-related statistics stretching back as much as 20 years for some data. This is complemented by community consultation findings, literature reviews and other contextual information tracing the development and progress of NPiS and the Safe Community. Very few other communities in New Zealand or overseas have such a comprehensive information resource covering such a long time frame.

In the 12 years since its inception, NPiS has played a significant role in fostering a more unified and focused effort by local agencies and groups to prevent injury and promote safety in New Plymouth District. This work has been underpinned by the principles and objectives of the International Safe Communities movement and included a focus on building and maintaining positive collaborative networks and alliances between local agencies and groups, collecting and disseminating locally-relevant injury and safety data, identifying gaps and needs, developing agreement on local injury and safety priorities, and co-ordinating the design and delivery of ongoing and one-off injury prevention and safety projects and programmes.

Feedback from local agencies and organisations about the performance and usefulness of NPiS has generally been very positive and supportive in all three needs assessments. The current assessment included a close look at perceptions of the value and impact of NPiS's work and showed that people from agencies and organisations linked to NPiS are on the whole highly appreciative and respectful of NPiS's efforts. They recognise a number of ways NPiS has been genuinely effective in helping to develop a more co-ordinated approach to injury prevention and safety promotion in the district.

More broadly, a number of key local injury statistics have shown improvements over the years NPiS has been operating. Perhaps the most clear cut are the reductions in injury hospitalisation rates recorded between 2003 and 2007. These are all the more notable for the fact they occurred in the context of an overall increase in injury hospitalisation rates across New Zealand as a whole.

Despite these positive injury and safety outcomes, it is not possible to state definitively that the actions of NPiS or the wider New Plymouth Safe Community have clearly contributed to these improvements. This is because of the limitations of routinely-collected injury and safety data and of available research methods – a problem that is common to most evaluations of community initiatives and not unique to the present study. That said, it is probably fair to suggest that at least

some of these improvements are likely to be a result of the concerted efforts of agencies and groups in the New Plymouth Safe Community, facilitated and encouraged by NPiS.

Funding issues, loss of the programme manager and a move to cover a wider range of safety issues have been challenges for NPiS in the past year or two. However, ACC's recently-announced new funding model offers the Trust a possible opportunity to employ a new programme manager in the near future. This would undoubtedly boost NPiS's capacity to maintain and further develop its work in the years ahead, building on its long track record of positive action in the local community.

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Plus five other people who did not wish to have their names listed.