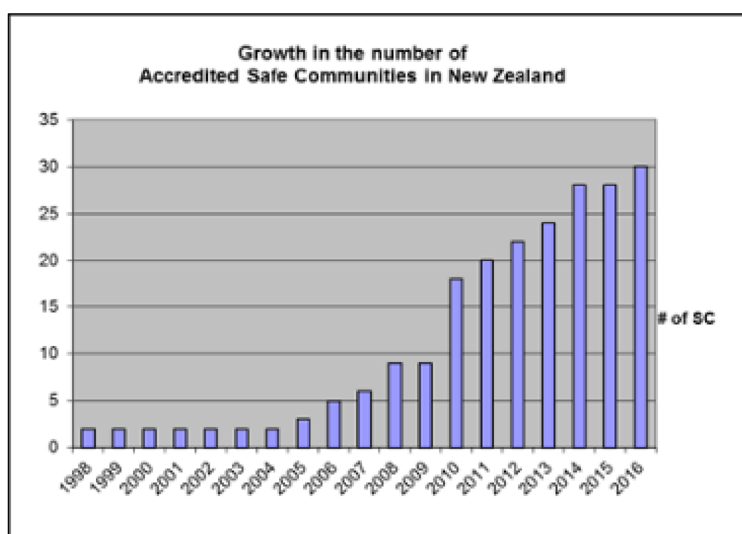
Understanding the role, benefits and costs of Safe Community Coordination at local and national levels

Discussion Document

Safe Communities is not another project or a programme, it's an integrated way of doing business. Accreditation as a Safe Community formalises your commitment to continue to work in a collaborative and systematic way. Accreditation as a Safe Community based on the Safe Communities model is recognised by World Health Organization (WHO) and worldwide as an effective and acceptable intervention to improve community safety. New Zealand forms part of the Pan Pacific Safe Community Network (PPSCN).

Safe Community Foundation New Zealand (SCFNZ) National Office

SCFNZ, a non-government organisation with charitable trust status, is an Accrediting Centre of PPSCN and International Safe Community Support Centre. SCFNZ adopts both public health and community development approaches to safety promotion, injury and violence prevention. SCFNZ was established in 2004, and since its inception there has been exponential growth of safe communities within NZ.



SCFNZ was created to specifically support communities become effective advocates and enablers of injury and crime prevention at community level. SCFNZ works with the existing and new community coalitions to grow and strengthen community safety activities, to create safer environments, and increase the adoption of safer behaviours. SCFNZ supports and encourages community governance groups to build safety capacity and achieve recognition under the international criteria as accredited Safe Communities.

Key SCFNZ focus areas include:

1) Support communities capability and impact in identifying high risk injury areas (focus on what is important)
2) Mentoring to create effective coordination of community efforts
3) Strengthen communities capacity and capability in mobilising actions
4) Community evaluation to demonstrate contribution in reducing injury

Accredited Safe Communities provide the ideal platform and channels for central and local Government to reduce injuries, violence and crime through a focus on high risk groups and

environments, and through leadership, partnerships and collaboration. Government has a focus on "investing for outcomes", and an underlying expectation that this will be accomplished collaboratively: a whole-of-government approach. Because of this there is a need for wide-ranging collaboration and the greater involvement of target communities in the design and delivery of services. Communities need to understand and take ownership of issues facing them, and exercise greater autonomy in the design and delivery of services and programmes.

It is worth noting that in the 17 years since Waitakere City became the first accredited Safe Community (1999), through to 2016 when Invercargill/Southland became the 29/30th local authorities to gain accreditation, not one city or district has withdrawn from the Safe Communities programme. Quite the opposite, the movement continues to grow and strengthen in the face of fiscal constraints, changing bureaucratic priorities and demands, and organisational restructuring amongst partner agencies. There are currently two communities in accreditation process, two more inquiring, and Auckland Council is entering the pre-accreditation phase.

These outcomes are primarily for two reasons: the Safe Communities programme actually works in NZ; and SCFNZ provides capable leadership, direction and support on a minimal budget.

The tools used by SCFNZ to support the Safe Communities network are:

- Assisting communities to develop and sustain Safe Community initiatives
- Developing strategic policy &operational advice & support
- Developing relevant injury prevention and safety promotion resources
- Scheduling regional forums, training and development
- Supporting communities to profile their injury/crime burden and proceed on an evidence base
- Maintaining prompt and effective communications with Coordinators and Chairs
- Local level mentoring and support from competent and experienced staff
- Analysing of Annual Reports and Governance Group Surveys from every Safe Community
- Conducting the Annual National Hui
- Advocating and liaising with central government and national NGOs
- Exercising leadership and advocacy with PPSCN, and WHO

SCFNZ has both the capacity and capability to provide ongoing services to the local, regional, national and international Safe Communities movement.

The Safe Communities model is aligned with and provides a platform for the achievement of central government objectives including: ACC priorities and programmes; NZ Health Strategy; Ministry of Health and Health Promotion Agency focus on reducing drug and alcohol-related harm; 'Delivering Better Public Services' objectives; Ministry of Justice 'Drivers of Crime' initiative; NZ Police Prevention First Strategy; NZTA 'Safer Journeys 2020'. The cross-government Injury Prevention Work Plan is an expression of the government's commitment to working with organisations and groups in the wider community to improve the country's injury prevention performance.

In NZ, the Safe Communities accreditation programme is mindful of the issue of attribution and recognises that no one agency or initiative can assume sole responsibility for reducing the injury/violence burden.

ACC Evaluation of SCFNZ and Safe Communities

ACC commissioned UMR research to undertake an independent evaluation of the Safe Communities model operating in NZ and the work of the SCFNZ. This evaluation was undertaken in late 2009.

Key findings include:

- ☐ Strengths of the Safe Communities model operating in New Zealand are that it has:
  - an internationally backed framework of operation
  - the support of local government
  - encouraged community buy-in
  - led to coordinated community efforts that address injury and violence prevention
  - supported local Safety Coalition groups to work well.
- ☐ The goals of the Safe Community model were seen to be creating an environment that embraces a holistic view of community safety, where communities work together to ensure their citizens can live safely, both in terms of unintentional injuries, violence and crime.
- ☐ Having the Safe Community framework that included a data collection and evaluation component was found to be useful in keeping communities centered on achieving overall community safety goals for their community.
- ☐ The Safe Community model supports the principles of the NZ Injury Prevention Strategy and ACC. Additionally, ACC was found to have the services of an organisation, the SCFNZ, which is focused on supporting communities to work to the Safe Community model thus releasing ACC staff to work on other injury prevention initiatives.
- ☐ Using an outcomes model, participants were able to identify areas where outcomes are being met and also areas where performance could be improved. Currently many of the lower-level outcomes are being achieved setting a strong platform for achievement of higher-level outcomes.
- ☐ Numerous examples were given where Safe Communities are performing well. These included:
  - Police working more in partnership rather than in isolation.
  - Internal local council departments willing to listen to Safe Community concerns.
  - Localised injury prevention activities.
  - Working with Maori.
  - Working with businesses.
  - Enhanced collaboration and networking.
- ☐ The Safe Community model provides confidence that the programme and initiatives are operating within a connected community environment.
- ☐ Being an accredited Safe Community increases confidence of accountability for funding providers.
- ☐ SCFNZ received very high praise for its achievements. “SCFNZ provides a robust and professional service to Safe Communities in a responsive and timely manner. Their expertise and support is well recognised and, most importantly, there is a feeling of partnership and mutual respect that Safe Communities participants value.”

International Support

Providing the international structure, support and coordination is the Pan Pacific Safe Communities Network (PPSCN) representing almost 110 accredited Safe Communities in Australia, Canada, New Zealand and the United States. As an advocate for injury/violence prevention the PPSCN promotes evidence based programming, leadership, sustainability, evaluation training, mentors communities, conducts accreditations and provides networking opportunities.

PPSCN has operated since 2010 (registered NGO 2013) and was established due to changes in the centralized infrastructure of International Safe Communities. In 2014, PPSCN began pursuing official relations with the World Health Organization (WHO) to establish opportunities to work on specific projects to advance our mutual goals of developing sustainable, equitable and transferable violence and injury prevention models at the local level.

As evidence of the growing strength of this relationship, in October 2015 World Health Organization Western Pacific Regional Office (WPRO) contracted with SCFNZ to deliver training in Violence and Injury Prevention to representatives from five Pacific nations: Fiji, Samoa, Tonga, Kiribati and the Solomon Islands. WPRO has just released the Regional Action Plan for Violence and Injury Prevention. The plan identifies the need for effective coordination and collaboration, and references the Safe Communities model, and includes the PPSCN website as a resource.

WPRO: Regional Action Plan for Violence and Injury Prevention in the Western Pacific (2016-2020). excerpt

Effective coordination and collaboration requires leadership from the highest levels of government. Political commitment at the highest levels of government enables intra-ministerial cooperation, cross-sectoral collaboration, allocation of resources and social change. Examples of sectors that are often involved in the prevention of major subtypes of violence and injuries include health, police, justice, transport, finance, infrastructure, planning, education, housing, labour, and urban and rural development.

Leadership and coordination

- The determinants of violence and injuries are intersectoral and multidisciplinary, so effective action for injury prevention requires a whole-of-government approach.
- Adopt strategic approaches for the delivery of evidence-based interventions such as the Safe Communities model.

Tools and resources for violence and injury prevention: Pan Pacific Safe Communities Network http://www.ppscn.org

Improving community safety is complex and the collaboration necessary to address injury prevention is challenging but not impossible. The PPSCN is an essential component to developing the capacity of communities to focus on the adoption of an integrated approach to planning and delivery based on the available evidence.

Safe Community Coordination: local

There is no 'one size fits all' formula for Safe Communities. Each area creates its own structures, priorities and activities that are appropriate and responsive to local needs and conditions. Local Authorities are usually engaged, along with key stakeholders including Police, ACC, Fire Service, District Health Boards, local Iwi, and other community agencies.

- There are currently 24 accredited Safe Communities covering 30 local authorities, with two more in pre-accreditation, and two prospective (including Auckland Council).
- All accredited Safe Communities have a paid coordinator. Most are contracted/employed on a part-time basis. Several undertake the role as part of a fulltime salaried position within a local authority. There are variations in the hours, rates of pay, and conditions of employment
- As a result in 2015, SCFNZ released a discussion document that could be used as a basis for formulating Coordinator positions. SCFNZ is indebted to Whanganui District Council for formulating and job-sizing/salary banding the Coordinator role for Safer Whanganui. It is our view that the coordinator role is fundamental to the success of Safe Communities, and needs to be resourced and staffed at an appropriate level.
- Key elements in the role include: strategic planning; relationships management; interagency networking and collaboration; data analysis and reporting; project planning and delivery.
- Coordinators are expected to have qualifications in health, education or social sciences, and have skills and experience in planning; community development; partnerships and collaboration; project management; Iwi/Maori and other cultural engagement.

- They are expected to have specialist knowledge and stay informed about injury prevention, crime prevention and community safety policy and practice; and be aware of the data, trends, issues and gaps within their local community.
- Coordinators are highly skilled facilitators, enablers, leaders, and communicators. They are able to work autonomously, and within multi-disciplinary teams. Coordinators transcend organisational boundaries (silos) and actively promote partnerships and collaboration.

Understanding the benefits

This next section references recently published research by Dr Dale Hanson, Queensland. **The reference is: *Dale Hanson, DrPH, MPHTM, MBBS et al, Working From the Inside Out: A Case Study of Mackay Safe Community, Health Education & Behavior, 2015, Vol. 42(1S) 35 S–45S***

Dr Hanson and colleagues have undertaken a series of evaluations of the Mackay SC utilising an ecological model. A social network analysis conducted in 2000 and 2004 indicated that the network doubled its cohesiveness, thereby strengthening its ability to collaborate for mutual benefit. This corresponds with the Annual Governance Group Survey undertaken by SCFNZ which measures the synergy within Safe Community governance groups using a variety of scales.

The research identified two forms of connected relationships:

1. *Bonding relationships*: increasing the density and strength of relationships within groups strengthened the ability of the coalition (governance group) to collaborate for mutual benefit.
2. *Bridging and linking relationships*: these boundary-crossing relationships connected subgroups within the community (bridging relationships) and connected the community to external agencies (linking relationships). These relationships proved to be a critical conduit for the sharing of resources.

Dr Hanson reports that these boundary-spanning relationships accessed an estimated 6.5 full-time equivalents of human resources and US$750,000 in 2004 that it used to deliver a suite of injury control and safety promotion activities, associated with a 33% reduction in injury deaths over the period 2002 to 2010.

These findings are consistent with other Safe Communities. For example, in NZ, Tauranga Moana Safe City attracted more than $2million in external funding that contributed to funding for coordination, and for the delivery of safety promotion programmes over an 8 year period.

The role of the Safe Community coordinator is therefore critical to the development and strengthening of the bonding relationships within the leadership/governance and wider community coalition; and the bridging and linking relationships that encompass external agencies and funders.

The coordination role brings an added dimension to the identification and resolution of wicked issues/problems (complex): particularly the ones that are not the mandate or responsibility of any one agency, for example alcohol-related harm. Family violence, suicide prevention, sexual violence are some other areas that transcend silos and boundaries. These issues reach across multiple agencies and sectors but where there is no incentive or capacity within any one agency to create 'linking relationships' that can result in multi-faceted approaches.

Understanding the value of collaboration

A core underlying principle of Safe Communities is collaboration. A second core principle is self-determination. By definition, Safe Communities is a platform and enabler of community-level initiatives.

In December 2015, Social Policy Evaluation and Research Unit, MSD, published a report*:* *Effective community-level change: What makes community-level initiatives effective and how can central government best support them?*

The Report notes:

The purpose of the project was to inform the Ministry about what works in community-level initiatives, and how central government can best support effective community-level initiatives. For the purposes of this project, community-level initiatives are defined as those that:

1. do not provide services to individual clients;
2. have a significant community engagement component; and
3. are aimed at addressing community-level issues and outcomes such as social connectedness, tino rangatiratanga/self-determination, incidence of family violence, and crime rates.

Key principles:

- Community self-determination: the ability to have a voice, to participate and to exercise control over one's destiny
- A focus on the strengths and assets of communities and the importance of their knowledge base
- A holistic and ecological approach, recognising the interconnectedness and complexity of factors and outcomes at various levels: individual, family, community, society
- A focus on **process** and **relationships** as well as **tangible outcomes**.

Success factors:

- A shared vision, owned by the community
- Community readiness
- Intentionality and a focus on outcomes
- Long-term and adaptable funding arrangements
- A focus on community capacity-building
- Skilled leadership and facilitation
- Processes for addressing power imbalances
- A focus on relationships
- Appropriate scale
- Continuous learning and adaptation.

Barriers to success (excerpted)

- Adverse funding and accountability arrangements
- A central-government culture that is not well-aligned to working with communities
- Lack of focus on addressing 'upstream' factors
- Loss of funding

Understanding the cost
The following report from the UK comments on the barriers to moving towards prevention. It focuses mainly on the issues surrounding funding, return on investment, budgets and business cases. The points raised in this report mirror the situation in NZ.

Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays, UK
Action, inaction and barriers to progress

<u>The report notes:</u>

The perceived time lag between investment and benefit, which means that any savings are not likely to be realised in any given financial or political cycle

- The reality that investments from one budget/department/agency may be required to bring benefits to another, limiting budget holders' willingness to take action
- Lack of sufficiently compelling evidence that interventions will lead to promised outcomes, and therefore difficulty in passing a 'business case' test
- Lack of incentives for different parts of the system to grapple properly with the challenges of shared goals, let alone pooling or aligning budgets
- Absence of sufficient data to understand fully the costs of existing approaches and therefore the real costs of inaction
- Lack of resources to invest in up-front prevention while acute need is ongoing
- Lack of a workforce that understands the benefits of evidence-based practice, has the tools to implement it, and is sufficiently settled and secure to deliver ambitious change
- The many challenges of disinvestment – it is difficult to stop doing those things which may not be working effectively but are part of the accepted local landscape in order to reinvest
- Lack of encouraging examples of prevention delivered at population scale which have successfully reduced demand for 'late intervention' services

Identifying the costs associated with major crime, violence and injury problems is challenging. The nature of the evidence means that our estimates are indicative. Differences in definitions, limited data on costs, variety in the ages for which there is evidence and the challenges in generalising from one context to another with different health and wider social welfare systems are among the most significant hurdles. **Pinpointing the savings from particular interventions is even harder as the data uncertainties are multiplied.**

The following table shows the levels of government investment in injury prevention. With the exceptions, perhaps, of motor vehicle traffic crashes and assault, the expectation that significant changes/reductions in injury claims/costs can be achieved with such minimal investment is unrealistic. When you consider the distribution of funding and the abbreviated contracting timeframes you begin to appreciate how difficult it is to link that level of investment with any statistical outcomes such as reductions in injury claims and costs. ACC Statement of Intent 2015 – 2019 anticipates a Return on Investment of $1.15/$1.00 or 115%. Even if this is being achieved it is almost impossible to prove.

TABLE 12: ESTIMATED GOVERNMENT EXPENDITURE ON INJURY PREVENTION AS A PERCENTAGE OF TOTAL SOCIAL AND ECONOMIC COST

Priority area	Total social and economic cost (O'Dea and Wren, 2009)	Estimated government expenditure	Expenditure as a percentage of cost
Motor vehicle traffic crashes	$2,195,000,000	$854,000,000	38.9%
Suicide and deliberate self-harm	$2,169,100,000	$25,000,000	1.2%
Falls	$1,735,200,000	$9,000,000	0.5%
Workplace injuries	$1,347,500,000	$85,000,000	6.3%
Assault	$379,600,000	$122,000,000	32.1%
Drowning	$295,500,000	$10,000,000	3.4%
Totals	**$8,121,900,000**	**$1,105,000,000**	**13.6%**

14. O'Dea, D., & Wren, J. 2010. New Zealand Estimates of the Total Social and Economic Cost of "All Injuries" and the Six Priority Areas Respectively, at June 2008 Prices: Technical report prepared for NZIPS evaluation. Wellington: University of Otago and Accident Compensation Corporation.

Safe Communities: added value

One aspect of Safe Communities that can be estimated/quantified is the value-added content at governance and service delivery levels. SCFNZ is doing some analysis of the value-added contribution of partner agencies in terms of hours and resources.

Governance: within the Safe Community network, governance groups range in size from 6 to 22 (Christchurch) and 23 (Wellington). The average is 13. Based on reports, these groups meet on average 8 times per year. Let's assume:

- number of Safe Communities = 24
- number of meetings = 8
- 75% attendance = 9
- Length of a meeting allowing traveling time is 3 hours
- Average salary of members = $104,000 FTE calculated at $50 per hour

Annual value of contribution per SC: $10,800
Annual value of contribution (national): $259,200.00
This does not include the in-kind collateral benefits including use of office/meeting room, secretarial and admin services.

Projects/activities: one of the benefits of partnerships and collaboration is that the partners bring money, time and resources to the table.

Safer Napier

As part of a thorough independent review of their programme, Safer Napier analysed the funding contributions of partner agencies over the first five years post-designation:

Table 2: Amount of directly attributable funding via Napier City Council (NCC) 2010-2015

Funder	Amount
ACC	$106,000
HB DHB	$6000
HPA	$3700
HPA to DHB	$3600
Min. Youth Development	$65,000
Min. of Justice	$5000
NCC	$217,183
Ravensdown	$5000
Total	**$411,483**

In addition to this total, a further estimated **$1,285,000** of “other safety focused funding via NCC” was indirectly attributable to the programme including: funding for Surf Lifesaving NZ, Napier Safety Trust (CCTV), NCC (Civil Defence) and Ministry of Justice (Crime Prevention).

Safer Napier Overall Conclusion

“Overall, from the information obtained it can be concluded that the Safer Napier programme contains a portfolio of projects designed to reach a wide range of target groups on which they have a moderate to high impact and delivers reasonable value for money. Crime prevention and road safety projects appear to have most impact and alcohol-related harm the least, although there is insufficient outcome information to be very definitive in this regard. The evolution of the portfolio across time points to the increasing maturity of the programme that delivers a range of outcomes including increased awareness but perhaps more saliently, crime reduction, a safer physical environment and positive behaviour change.” Katoa Ltd, April 2015.

Safer Waimakariri

In February 2016, Safer Waimakariri undertook an exercise to calculate the added value of partner contributions in cash and kind to the delivery of specific programmes. The analysis demonstrated that for programmes delivered in Suicide Prevention (below) there was a real dollar return of 135% or in other words: for every $1.00 of Ministry of Health funding, it was matched by a contribution of $1.35 from partners. Falls Prevention demonstrated a return of approximately 90% or $0.90 for every $1.00 from MOH. Rural programmes achieved $0.74 for every $1.00, and child safety $0.84 for every $1.00 in 'added value'

SUICIDE PREVENTION Value Breakdown over 1 year of delivery

Partners: *CDHB (including School Based Mental Health), Depression Support Network, Local Schools, Pegasus PHO, Neighbourhood Support, Hope Community Trust, Oxford Community Trust, Grey Power, Com Care Trust, Presbyterian Support, Whanau Champion Ngai Tahu Farms, North Canterbury Sport and Recreation Trust, Waimakariri Youth Council, Victim support, Male Survivors of Sexual Abuse, Rural Canterbury Primary Health Organisation, NZ Police, R13 Trust, Wellbeing North Canterbury, Enabling Youth, 298 Youth Health, Local GP, Family Planning, Waimakariri Access Group and community members. Road Safety Co-ordinator, Safe Community Facilitator, Rural Support Trust, Wisdom Counsellor,*

Activities include:

1. Establishment and facilitation of Wai Life Suicide Prevention Steering Group
2. Review, re-establishment and support for Waimakariri Bereaved by Suicide group and waves programme
3. Facilitation of local QPR Suicide Prevention training initiatives
4. Workshops on wellbeing, depression and how to address signs of potential suicide. (E.g. Depressions Awareness workshop at Rangiora Library, Oxford Youth Forum, Good Bad and Ugly Parenting Teens seminar) approx. 3 days each
5. Facilitation of Community-Led initiatives to support connection and wellbeing in rural communities. (E.g. Funky Farmworkers' Food and Farm Strong)
6. Facilitating links to assist with the establishment of the Oxford 'Got Your Back' initiative; aimed at ensuring that community members have someone they can turn to in a crisis.
7. Development of locally relevant on-line resources
8. Engagement in regional fora to establish practitioner links
9. Local research and associated links (e.g. in relation to contagion, or accessing local stakeholder evidence)

Activity	**# of Partners**	**Residents reached**	**Coordinator Hours** (per year)	**Coordinator cost:** (including rent, IT, etc)	**Project costs**	**Partner hours**	**Cost in kind** (averaged at $30 per volunteer hour)	**Total Health Promotion value**	**Total investment from MOH**
1	42	Whole of population promotion; but with targeted groups, project dependent	114	$ 4,446	$ 200	1680	$ 37,800		
2			140	$ 5,460	$ 500	34	$ 1,020		
3	Over whole suicide portfolio		48	$ 1,872	$ 920	38	$ 1,140		
4			56	$ 2,184	$ 900	160	$ 4,800		
5			80	$ 3,120	$ 750	128	$ 3,840		
6			80	$ 3,120	$ 750	12	$ 360		
7			64	$ 2,496	$ 1,190	2	$ 24		
8			96	$ 3,744	$ 200				
9			40	$ 1,560	$ 100				
TOTAL	**42**	**60,000**	**718**	**$ 28,032**	**$ 4,160**	**358**	**$48,984**	**$75,732**	**$32,192**